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REAUTHORIZATION OF THE ADOLESCENT FAMILY LIFE DEMONSTRATION PROJECTS ACT OF 1981

HEARINGS

BEFORE THE

SUBCOMMITTEE ON
FAMILY AND HUMAN SERVICES

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

ON

AN OVERVIEW OF THE ADOLESCENT PREGNANCY PROBLEM AND REAUTHORIZATION OF TITLE XX OF THE PUBLIC HEALTH SERVICE ACT: THE ADOLESCENT FAMILY LIFE DEMONSTRATION PROJECTS ACT OF 1981

APRIL 24 AND 26, 1984

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REAUTHORIZATION OF THE ADOLESCENT FAMILY LIFE DEMONSTRATION PROJECTS ACT OF 1981

TUESDAY, APRIL 24, 1984

U.S. Senate,
Subcommittee on Family and Human Services,
Committee on Labor and Human Resources,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:05 a.m., in room SD-430, Dirksen Senate Office Building, Senator Jeremiah Denton (chairman of the subcommittee) presiding.

Present: Senators Denton and Grassley.

OPENING STATEMENT OF SENATOR DENTON

Senator Denton. Good morning

I would like to welcome our witnesses and guests to the first of two hearings on the reauthorization of the Adolescent Family Life Demonstration Projects Act of 1981, title XX of the Public Health Service Act.

Today we will receive testimony from the officials of the Department of Health and Human Services who are responsible for administering the law, Dr. Edward Brandt, Assistant Secretary for Health, and Mrs. Marjory Mecklenburg, Deputy Assistant Secretary for Population Affairs and Director of the Office of Adolescent Pregnancy Programs. They are here at the witness table now.

Mrs. Mecklenburg has the direct responsibility for running the Adolescent Family Life Program.

Our other witnesses are representatives from Adolescent Family Life projects. We also have with us this morning two young women who have received services from Adolescent Family Life projects. I am looking forward to the opportunity to hear from some of the people most directly involved in providing and receiving Adolescent Family Life services during the period since the enactment of the law in 1981.

The passage of this law by the Congress in 1981 was a considerable accomplishment. As a newly elected Senator and as chairman of this Subcommittee on Family and Human Services, noting the alarming number of adolescent pregnancies and abortions rising in spite of major Federal expenditures for policies to deal with the problem, I came to believe strongly that new and different approaches had to be found for alleviating the problems. We found a different way.

I was fortunate that the chairman of the Labor and Human Resources Committee, Senator Hatch, strongly supported my endeavor to develop workable legislation. My efforts also depended on the involvement of the ranking minority member of the Committee, Senator Kennedy. It was his law, the Adolescent Health Services and Pregnancy Prevention and Care Act of 1978, that served as the foundation for the development of the Adolescent Family Life Act. Senator Kennedy did support the Adolescent Family Life Act and worked with me to gain the unanimous support of the Labor and Human Resources Committee for its passage.

As a result of that bipartisan effort, the Adolescent Family Life Act was enacted into law as part of the Omnibus Budget Reconciliation Act of 1981. It was readily embraced by the Reagan administration as an essential demonstration of a desirable approach to addressing our Nation's adolescent pregnancy problem.

The Adolescent Family Life Act has a threefold purpose. First, prevention demonstration programs around the country are helping teenagers and their parents to work together, with the assistance of outside advisers and counselors, to exchange views and to examine the values of family life and sexuality.

Second, care demonstration programs are providing comprehensive services to help pregnant adolescents and their families throughout the pregnancy, delivery, and care of the babies.

Third, Federal funds are being used for practical research into the causes, consequences, and means of discouraging premarital sexual relations and of reducing adolescent pregnancy, and for evaluation of the best kinds of programs for adolescent parents.

I personally am a supporter of family life and sex education. My experience in that area, for 10 years, including the last 3 years as a Member of the Senate, has shown me that parents are not necessarily the only and best source of information about sexuality for their own children. I have found, however, that the best sex education includes the parents and relies upon the cooperation of teachers, social workers, the medical community, and representatives of community and religious organizations with parents to develop the curriculum.

The Adolescent Family Life Act provides an opportunity for demonstration projects throughout the country to involve parents along with their children in learning and communicating about sexuality and the problems of adolescent pregnancy.

One purpose of the law is to support the development of prevention demonstration projects at a local level to encourage teenagers to refrain from premarital sexual relations and to involve their families so that they have a chance to help their children to develop and reinforce their decisions. The Adolescent Family Life Act provides the seed money for projects that, among other things, attempt to deal with the problem in ways different from before, namely, by developing sex education programs that present more than simply biological facts, birth control pills, and abortion when birth control fails. That was the approach in which the Government was involved when I came to the Senate.

Another purpose of the law is to provide funds for the development of model care programs which provide supportive services to pregnant adolescents. These young pregnant women are linked up with health, educational and counseling services in their communities. The care programs also direct their services toward the young men involved. These programs rely heavily on the cooperation of other community and religious organizations, as well as on their families.

Thus, the Adolescent Family Life Act places a significant emphasis on the involvement of parents with their children in the demonstration projects. The reason for the requirements for parental consent and family involvement in programs conducted under the act is to provide program administrators, counselors, and researchers with the opportunity to evaluate the principle that family involvement in sex education and adolescent pregnancy programs should be the rule rather than the exception.

Although I am firmly convinced that Government-funded programs should and must acknowledge the family as the first line of defense in dealing with the problems of adolescent pregnancy, I am continually exploring the best possible approaches to ensure that parents are granted the privilege of exercising their inalienable right and obligation to be properly involved in federally supported sex education and adolescent pregnancy programs that serve their children. The demonstration projects that have been initiated under the Adolescent Family Life Act offer examples that we should observe and from which we can learn.

One of the other major thrusts of the Adolescent Family Life Act is to present adoption as a positive alternative for adolescent parents to consider. The prevention and care projects funded under the act are required to provide information about the adoption option and to establish formal linkages with agencies that are licensed to provide adoption placement services, as well as maternity residential services. Adolescent Family Life projects are currently testing new approaches to see how adoption can be better presented to and understood by adolescents and their families. Research is also being conducted to ascertain the current attitudes about adoption, as well as to determine the requirements for successful adoption planning by young parents.

Today, we will hear about the results of one research project on adoption that is funded by the Adolescent Family Life Act.

Through the adoption emphasis, the Adolescent Family Life Act is providing demonstration projects opportunities to develop better techniques for counseling. Teenage parenthood is not the only, nor necessarily always the best alternative to teenage abortion. By providing funds for projects developing adoption counseling services, we are giving renewed support to another option that can provide positive outcomes for both the adolescent parents, and not unimportantly, the baby. Adoption also provides an opportunity for many waiting couples to become loving adoptive parents.

The Adolescent Family Life Act is one Federal Government program that acknowledges the need for supportive services to pregnant adolescents as an alternative to abortion. To that end, the act specifically restricts the activities of the demonstration projects by prohibiting abortion counseling, referral to abortion clinics, or payment for abortions. If both the adolescent and her parents request information about abortion, however, a referral for abortion counseling can be provided.

Through the demonstration approach, the Adolescent Family Life Act is assisting in the development of workable and effective programs for adolescents and their families who might otherwise turn to an abortion when faced with an unintended pregnancy. That aspect is a very important factor for many who support the Adolescent Family Life Program, both here in the Congress and in the local communities where the demonstration projects are located. The act provides an alternative approach to demonstrate to adolescents and their parents that options other than abortion do exist in their communities.

I am firmly convinced that the demonstration effort is worthwhile and that it is a necessary addition to the current Federal repertoire of family planning services and programs to pregnant adolescents.

There are, however, individuals and organizations who are opposed to the thrust of the Adolescent Family Life Act. That fact has been most recently demonstrated by a lawsuit filed in the Federal district court by the American Civil Liberties Union. The ACLU contends that because traditional charitable religious groups are receiving grants to help young people and their families, programs conducted under the authority of the act violate the first amendment to the Constitution. The argument contends that because programs funded by the Adolescent Family Life Act are not in all cases required to counsel and promote abortion, they have embraced a Government-approved religious doctrine. One of the plaintiffs represented by the ACLU, the American Jewish Congress, was invited to testify before this subcommittee, but declined. Before the invitation was given, they had indicated a desire to testify.

The courts will have to decide whether the law as passed by Congress is constitutional. The task before the subcommittee and the Congress is to oversee the activities of the current act and to see that the intent of the law is being carried out.

As chairman of this subcommittee and as the sponsor of the Adolescent Family Life Act, I will examine objectively the criticisms as well as the compliments. I will, however, defend the intent of the Congress to allow religiously affiliated organizations, as well as nonsectarian groups, to provide alternatives to abortion services. That seems to me to accord with the current Federal Government policy of no longer paying for abortions. I believe that those provisions of the law will have the continued support of most of my colleagues in the Senate and in the House.

The Adolescent Family Life Act is not a large Federal program. It is purposefully a small demonstration approach. There are currently 59 demonstration projects, 18 research projects, and a technical assistance project operating in 39 States, Guam, and the District of Columbia, utilizing $15 million total in Adolescent Family Life funds.

Each of the demonstration projects is required to develop an evaluation process so that its program can be tested, and those programs shown to be effective can be replicated in other communities. The projects can receive Federal funds only for a maximum of 5 years. The majority of the projects are in the first or second year of their programs. When the 1984 grant awards are made, by September 30, 1984, there will be several new projects initiated.

Obviously, we do not have the final results or accomplishments of the programs. The evaluation process is just getting started. We do have the chance this morning to receive reports from several Adolescent Family Life grantees who will describe their programs and accomplishments to date. I have asked each witness, if he wishes to do so, to make recommendations for the improvement of the act.

I will soon introduce a bill to reauthorize the Adolescent Family Life Act for 3 years, at the current authorization level of $30 million per year. I expect a strong bipartisan effort by the members of the Labor and Human Resources Committee to report the bill as quickly as possible.

I am looking forward to hearing today's witnesses. Their testimony will be helpful to the subcommittee in determining the quality of the current Adolescent Family Life programs and the effectiveness of the Adolescent Family Life Act.

For the witnesses before me at the table, and for those others who will come to testify, I would like to say that in the interest of time, I and other subcommittee members who are unable to attend may wish to submit questions in writing, and I would ask that witnesses answer written questions within 10 working days of receipt. The record will remain open until such time as your answers are received.

Our first witness is Dr. Edward N. Brandt, Jr., the Assistant Secretary for Health of the Department of Health and Human Services. It is a pleasure to have you, Dr. Brandt. Dr. Brandt is accompanied by Mrs. Marjory Mecklenburg, the Deputy Assistant Secretary for Population Affairs and the Director of the Office of Adolescent Pregnancy Programs. Welcome, Dr. Brandt and Mrs. Mecklenburg.

If you have a prepared statement, Dr. Brandt, I am prepared to hear it.

STATEMENT OF EDWARD N. BRANDT, JR., M.D., ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND MARJORY MECKLENBURG, DEPUTY ASSISTANT SECRETARY FOR POPULATION AFFAIRS

Dr. BRANDT. Thank you very much, Mr. Chairman.

With your permission, I will submit a prepared statement and would like now to summarize it, if that is acceptable to you, sir.

Senator DENTON. Without objection, the written prepared statement will be submitted in the record as if read, and we will hear your summation.

Dr. BRANDT. I am very pleased to be here today with Mrs. Mecklenburg to discuss the Adolescent Family Life Program authorized under title XX of the Public Health Service Act.

Adolescent pregnancy and early sexual activity continue to be serious problems in the United States. In 1981, approximately 527,000 babies were born to adolescents 15 to 19 years of age, and over 9,600 were born to teenagers under 15 years of age.

The Adolescent Family Life Act was enacted by Congress in 1981 to prevent adolescent pregnancy by encouraging adolescents to postpone sexual activity and to minimize the adverse consequences for pregnant adolescents and their children. It also stresses the importance of family involvement and the presentation of adoption as an option for pregnant adolescents. The program funds demonstration projects that offer care and prevention services in different settings. Each model program has an evaluation component. After final evaluations have been completed, local communities will be able to adopt successful models.

The AFL Program also funds research projects, which will contribute to our knowledge of how to prevent teenage pregnancies and their adverse consequences.

The Department and the administration recommend that the Adolescent Family Life Program be reauthorized for 3 years. As long as premarital sexual activity and adolescent pregnancy remain serious problems, the Federal Government will have to play a role in supporting demonstration programs and research and in encouraging States to implement proven models of services.

Reauthorization of the program will also allow currently funded programs to complete their projects and evaluations.

For the remainder of my statement this morning, Mr. Chairman, I would like to discuss current program activities and preliminary results from model demonstration projects and research grants.

Funds were initially made available for the AFL program in late fiscal year 1982. The program is currently, as you pointed out, funding 59 model demonstration projects, 16 offering prevention services, 30 offering care services to pregnant adolescents and teenage parents, their infants, male partners, and family members, and 13 offering a combination of the 2. Sixteen research projects have been funded in the areas of premarital adolescent sexual relations, adoption, and services for pregnant adolescents and teenage parents. In addition, there are two research contracts, the first to create a data archive, and the second to conduct research on adolescent marriage.

Of the 59 demonstration projects, 44 are in health and social service agencies, 6 in hospitals, and 9 in universities or schools. Projects are located in rural as well as urban areas, and some involving multiple sites.

The AFL Act stresses the importance of the family in the prevention of adolescent sexual activity and pregnancy and in ameliorating the consequences of adolescent pregnancy.

These model demonstration projects encourage the involvement of the family in a variety of ways, which I have outlined in my testimony. Grantees offering prevention services provide family counseling, and have parents and adolescents attend activities together and in some instances, complete assignments jointly.

Title XX generally requires that grantees provide assurances that the projects will notify and will obtain the consent from parents or guardians of any unemancipated minor requesting services. Initial reports from these grantees suggest that the parental notification requirement can be workable.

Grantees offering core services are required to provide a variety of core services, including maternity counseling, primary and preventive health services, nutrition information and counseling, and educational and vocational services. In addition to these core services, grantees offer other services in an effort to minimize the adverse consequences of adolescent pregnancy.

All pregnant adolescents receiving care services from these projects receive counseling and information to help them decide whether to parent the child or make plans to have the child adopted. Adolescents who decide to keep their child receive the comprehensive care services outlined above; those who choose to make adoption plans receive these and additional services to help them carry out their decision.

The primary goal of the prevention services process is to determine which methods best encourage unmarried adolescents to postpone sexual activity and thereby reduce adolescent pregnancy. These projects are offering and evaluating a range of prevention services that should attain this. Research findings suggest that parental communication about sexuality leads adolescents to postpone early activity.

Since AFL demonstration projects are 3- to 5-year model programs and are just beginning their second year of operation, the final results are not available. However, grantees have provided preliminary data for their first year of operation. These preliminary findings indicated that the projects are making considerable progress.

After the projects collect several years of data and complete final evaluations, we will have a better understanding of the factors that contribute to differences in health outcomes for adolescent mothers and their infants when comprehensive services are available, versus those for teenagers and their children nationwide.

Title XX requires that each individual project conduct an evaluation of services and establish a working relationship with colleges or universities in its State to conduct these evaluations. In addition to assessing the medical outcomes of pregnant teens and their infants, AFL grantees offering care services are examining a number of other program outcomes, many of which are listed in my statement.

AFL has concentrated its research program on areas in which comparatively little research has been done, as outlined again in my complete statement. All of these projects are making progress, and some have reported preliminary findings.

Research done in the seventies revealed that growing numbers of teenagers are sexually active before marriage. In 1971, approximately 28 percent of adolescent females age 15 to 19 had engaged in sexual relations; in 1979, that figure was up to 46 percent. To help fill the gap in our knowledge and understanding, several AFL grants have been awarded. These projects are investigating many possible determinants of adolescent sexual relations, such as peer groups and schools, but all are giving particular emphasis to the role of the family. Researchers continue to find that the family plays a central role in encouraging adolescents to postpone sexual activity.

It also appears since the early seventies that fewer pregnant teenagers are placing their infants for adoption. The causes of this decline are not well understood, and therefore the AFL Program has supported several research projects on adoption. It has awarded other research grants that look at services for pregnant teenagers and adolescent parents. The researchers hope their study will indicate ways to improve services provided to pregnant adolescents and adolescents who raise their children.

When these model demonstration projects and research projects are completed, the dissemination of the final results will take place. Interim findings that appear reliable will also be announced on an ongoing basis. AFL research grantees are required to deposit public use data tapes in a data archive within 18 months after the end of their study. In this manner, the data now collected will be readily available to researchers and practitioners for additional analysis.

The AFL program has a major dissemination activity under way. It is sponsoring a data archive on adolescent pregnancy and pregnancy prevention at the American Institutes for Research. As of January 1984, this data archive contained 17 processed and documented data bases. There are an additional 27 data sets available for the archive, and we expect to complete processing of 17 of these by September of this year.

Thank you again, Mr. Chairman, for the opportunity to testify, and I and Mrs. Mecklenburg will be happy to answer any questions that you may have.

Senator DENTON. Thank you, Dr. Brandt.

[The prepared statement of Dr. Brandt follows:]

STATEMENT BY DR. EDWARD N. BRANDT, JR.

Mr. Chairman and Members of the Subcommittee:

I am very pleased to be here today to discuss the Adolescent Family Life (AFL) Program authorized under title XX of the Public Health Service Act. Accompanying me is Mrs. Marjory Mecklenburg, Deputy Assistant Secretary for Population Affairs.

Adolescent pregnancy and early sexual activity continue to be serious problems in the United States. Natality statistics for 1981 recently released by the National Center for Health Statistics show that teenage pregnancy continues to be associated with adverse health and social consequences. In 1981, approximately 527,000 babies were born to adolescents 15 to 19 years of age and over 9,600 were born to teens under 15 years of age. A larger percentage of teenage mothers began prenatal care later than older mothers did and teenage mothers in 1981 also were more likely than older mothers to have a baby with low birth weight.

The Adolescent Family Life Act was enacted by Congress in 1981 to prevent adolescent pregnancy by encouraging adolescents to postpone sexual activity and to minimize the adverse consequences for pregnant adolescents and their children. The Adolescent Family Life Act also stresses the importance of family involvement and the presentation of adoption as an option for pregnant adolescents. The program funds demonstration projects that offer care and prevention services in different settings. Each model program has an evaluation component. After final evaluations have been completed, local communities will be able to adopt proven models. The AFL program also funds research projects which will contribute to our knowledge of how to prevent teenage pregnancies and their adverse consequences.

The Department is recommending that the Adolescent Family Life Program be reauthorized for three years. As long as premarital sexual activity and adolescent pregnancy remain serious problems, the Federal Government will have to play a role in supporting demonstration programs and research and encouraging states to implement proven models of services. Reauthorization of the AFL program will allow currently funded programs to complete their projects and evaluations. Grantees will thus be able to provide extended services and follow-up to determine if pregnant adolescents and teenage parents complete school or find jobs and to determine if prevention activities provided to pre-teens and young adolescents lead to lower levels of teen sexual activity and pregnancy. This extended follow-up will provide us with more complete knowledge about effective services and model programs in the areas of adolescent pregnancy and pregnancy prevention. In the remainder of my statement this morning, I would like to discuss current program activities and preliminary results from model demonstration projects and research grants.

Current Activities

Funds were initially made available for the AFL program in late Fiscal Year 1982. Funds have been appropriated as follows: FY 1982--$10.9 million; FY 1983--$13.4 million; and FY 1984--$14.9 million. .The AFL program is currently funding 59 model demonstration projects. Sixteen of these projects offer prevention services to non-pregnant teens and their parents, 30 offer care services to pregnant adolescents and teenage parents, their infants, male partners and family members, and 13 offer a combination of care and prevention services. The Office of Adolescent Pregnancy Programs (OAPP) is funding 16 research projects in the areas of premarital adolescent sexual relations, adoption, and services for pregnant adolescents and teenage parents. In addition, OAPP has awarded two research contracts, the first to create a data archive and the second to conduct research on adolescent marriage.

Model Demonstration Projects

By funding a variety of projects in different regions and with different service delivery models, the AFL program will be able to identify effective strategies and models for use by State and local service providers. Of the 59 demonstration projects, 44 are in health and social service agencies, 6 are in hospitals, and 9 in universities or schools. Projects are located in rural as well as urban areas: 34 in urban areas, 19 in rural areas and 6 in areas where both urban and rural clients are served. The 59 projects are located in 39 states, the District of Columbia, and Guam. Demonstration projects offer services in a variety of ways —in single sites, multiple sites, or through linkage systems of existing community agencies. Still other projects use a combination of linkage agreements and single or multiple sites. Twenty-eight of the AFL model demonstration projects are located on single sites, ten on multiple sites; 15 are linkages and 6 are a combination of service delivery models.

The Adolescent Family Life Act stresses the importance of the family in the prevention of adolescent sexual activity and pregnancy and in ameliorating the consequences of adolescent pregnancy. AFL model demonstration projects encourage the involvement of the family in a variety of ways. Grantees offering care services provide family counseling, involve parents and male partners in prenatal sessions and provide information about adoption to parents and male partners. The participation of family members in these and other program activities with their adolescents is intended to draw upon the strength of the family and enlist its support in coping with the immediate and long term consequences of adolescent pregnancy. Grantees offering prevention services provide family counseling and have parents and adolescents attend activities together and in some instances complete assignments jointly.

As part of the Act's emphasis on involving the family, title XX generally requires that grantees provide assurances that the projects will notify and will obtain the consent from parents or guardians of any unemancipated minor requesting services. Initial reports from AFL grantees suggest that the parental notification requirement can be workable. To facilitate communication and to help pregnant adolescents talk with their parents project staff use such techniques as role playing and counseling.

Grantees offering care services are required to provide a variety of core services such as maternity counseling, primary and preventive health services, nutrition information and counseling, and educational and vocational services. In addition to the core services, grantees offer other are services in an effort to minimize the adverse consequences of adolescent pregnancy. To mention a few examples: on-site day care facilities which both assist adolescent mothers to complete their education and enable pregnant adolescents and teenage parents to receive instruction in child rearing and infant stimulation; a component that gives particular emphasis to employment training and counseling in such areas as employer-employee communication skills, career awareness, job search behavior, and supplementary job training; surrogate grandmothers to act as informal counselors and care givers; and vocational training for male partners to improve the educational outcomes and employment prospects for adolescent fathers as well as adolescent mothers.

All pregnant adolescents receiving care services from AFL projects receive counseling and information to help them decide whether to parent the child or make plans to have the child adopted. Adolescents who decide to keep their child receive the comprehensive care services outlined above; those who choose to make adoption plans receive these and additional services to help them carry out their decision. All AFL grantees offering care services provide adoption counseling and referral to licensed adoption agencies to pregnant adolescents who request these services. Certain projects also offer additional services that present adoption as a positive option to pregnant adolescents, their parents, and to teenagers and the community at large more generally. For example, at one project, teenagers are offered a variety of perspectives on adoption from people who have had personal experience with adoption such as birth parents, adoptive parents, and adoptees. Other adoption activities sponsored by AFL projects offering care services include peer support groups for pregnant adolescents, adoption information presented in prenatal classes, and a program of extended post-placement follow-up.

The primary goal of AFL projects offering prevention services is to determine which methods best encourage unmarried adolescents to postpone sexual activity and thereby reduce adolescent pregnancy. AFL projects are offering and evaluating a range of prevention services that would attain this. Research findings suggest that parental communication about sexuality leads adolescents to postpone early sexual activity. But further studies are needed. In any event, a number for projects offer classes and individual and family counseling to help parents feel more comfortable about communicating with their children in general and about responsible sexual behavior and other matters pertaining to sexuality in particular. In addition to working with parents, a number of projects include decision-making curricula in their program activities in order to help adolescents make mature decisions regarding sexual activity.

Since AFL demonstration projects are three to five-year model programs and are just beginning their second year of operation, the final results of these programs are not available. However, AFL grantees have provided preliminary data for their first year of operation. These preliminary findings indicate that the projects are making considerable progress.

While researchers have found that pregnant adolescents and their newborns are at greater risk than older mothers of experiencing health complications, most teenagers and their infants receiving care services from AFL programs experienced healthy outcomes. Since data are preliminary, we cannot make projections on impact at this time. However, after the projects collect several years of data and complete final evaluations, we will have a better understanding of the factors that contribute to differences in health outcomes for mothers and their infants when comprehensive services are available versus those for teenagers and their children nationwide.

Title XX requires that each individual project conduct an evaluation of project services and establish a working relationship with colleges or universities in its state to conduct these evaluations. In addition to assessing medical outcomes of pregnant teens and their infants, AFL grantees offering care services are examining other program outcomes. For example, one AFL project, which is providing services through a network of existing community agencies, is comparing the status of groups of pregnant and parenting clients in different tracks to determine the relative effectiveness of different combinations of on-site and off-site health care, schooling, and child care. Since prevention activities are offered in several formats to parents and teens together and in separate groups, the evaluation of a wide variety of prevention programs and models of service delivery will be possible. In addition to these individual efforts, a cross-cutting evaluation design which measures the relative effectiveness of various service models is being developed.

Research

AFL has concentrated its research program on areas in which comparatively little research has been done: the causes of premarital adolescent sexual activity, adoption, and services for pregnant teenagers and adolescent parents. All of the research projects are making progress and some have reported preliminary findings. As with the demonstration grants, AFL research projects are multi-year efforts and final results will not be available until the projects are completed.

Research done in the 1970s revealed that growing numbers of teenagers are sexually active before marriage. In 1971, approximately 28 percent of adolescent females age 15 to 19 had engaged in premarital sexual relations; in 1979, 46 percent. However, little was known about the causes of premarital adolescent sexual activity or how it might be prevented. To help fill the gap in our knowledge, several AFL grants have been awarded. These projects are investigating many possible determinants of adolescent sexual relations, such as peer groups and schools, but all are giving particular emphasis to the role of the family. For example, AFL research projects are analyzing data from samples of teens and parents. Researchers are finding that the family plays a central role in encouraging adolescents to postpone sexual activity.

It appears since the early 1970s that fewer pregnant teenagers are placing their infants for adoption. The causes of this decline are not well understood, and therefore, the AFL program has supported several research projects on adoption. Three of these adoption research projects focus on the factors which affect the adoption decisionmaking process among different population groups of unwed adolescent mothers. In another study, data from national surveys of women in 1955, 1973, 1976, and 1982 will be analyzed to describe trends in the propensity to adopt children and the charateristics of adoptive parents. This study will provide a base of knowledge about adoptive parents which can be used to better inform the public about adoption. In another study, researchers are interviewing a sample of pregnancy counselors concerning their attitudes and knowledge about adoption. Preliminary findings from this project indicate that while most counselors believe that adoption is advisable for adolescents, they know very little about adoption procedures. The final report from this project will have implications for practitioners in the field.

The AFL program has awarded other research grants that look at services for pregnant teenagers and adolescent parents. One study is comparing six cities with successful comprehensive services with six cities which do not have those services. Another study is describing the services available to pregnant teenagers in one city and the way they are being used by adolescents. A project sponsored jointly by the AFL program and the National Institute of Mental Health is examining ways to improve child rearing skills of adolescent mothers. In one preliminary observation, the researchers reported that the less mature adolescent mothers talk less to their babies and assume the baby's actions are more motivated than they actually are. The researchers hope their study will indicate ways to improve services provided to pregnant and adolescents who raise their children.

Dissemination

When the model demonstration projects and research projects are completed, the dissemination of the final results will take place. Interim findings that appear reliable will also be announced on an ongoing basis. Plans for dissemination include the use of communication channels such as professional journals, public forums and meetings, community newsletters, and the publications of state and local organizations which have an interest in adolescent pregnancy, child rearing, and pregnancy prevention. In addition, AFL research grantees are required to deposit public use data tapes in a data archive within 18 months after the end of their study. In this manner, the data now being collected will be readily available to researchers and practitioners for additional analysis.

The AFL program has a major dissemination activity underway. The AFL program is sponsoring a data archive on adolescent pregnancy and pregnancy prevention at the American Institutes for Research. This archive provides researchers, practitioners, administrators and policymakers with easy access to large-scale data on important issues in the fields of adolescent pregnancy and pregnancy prevention. As of January 1984, the data archive contained 17 processed and documented data bases. There are an additional 27 data sets available for the archive, and we expect to complete processing of 17 of these by September 1984.

Thank you for the opportunity to testify and I will be happy to answer any questions that you may have.

Senator **Denton**. Dr. Brandt, would you describe how this program has interacted and had an impact on coordinating with other Federal programs in reviewing ways to improve existing programs for pregnant adolescents?

What role has the prevention program played in stimulating other Federal efforts in this area, if any—and I welcome and solicit comments from Mrs. Mecklenburg, as well as from Dr. Brandt, on any of these questions.

Dr. **Brandt**. As you know, Mr. Chairman, the Office of Population Affairs has responsibility not only for the Adolescent Family Life Program, but also for the total Federal Family Planning Program.

In addition to that, the Public Health Service provides services to a number of beneficiaries, including the American Indians through the Indian Health Service, and through community health centers, all of which will benefit from the activities of these demonstration programs.

At the present time, we have begun a review of Federal policies throughout the Federal Government that in any way may affect the grantees and the beneficiaries of this program, and we will hopefully be making modifications required to implement to the greatest extent possible these findings.

Mrs. Mecklenburg, I am sure, will have additional comments.

Mrs. **Mecklenburg**. Senator, we meet with people in the Federal Government who have responsibility for programs such as Dr. Brandt has already mentioned, and additional programs such as maternal and child health, the Office of Families Program, and the Office of Human Development Services, who have responsibility for programs in the area of special needs the adoptions program, in order to see how we might best work with one another, understand each other's programs, and coordinate our activities with one another inasmuch as possible.

I think that one of the strengths of this legislation is the fact that it is multidisciplinary. There are opportunities for many sectors of the Government and the private sector to work together in order to solve this very important and serious problem.

Senator **Denton**. I want to welcome cordially my friend from Iowa, the distinguished Senator Charles Grassley. I hope you had a happy Easter, Senator.

Senator **Grassley**. I did have a very happy Easter.

[The following was received for the record:]

PREPARED STATEMENT OF SENATOR CHARLES E. GRASSLEY

I am pleased to join Senator Denton today and commend him for his initiative and leadership addressing one of the problems our society faces, that of adolescent pregnancy as we look toward the reauthorization of title XX—Adolescent Family Life Demonstration Project Act. I am pleased to see that the emphasis of this program is that of preventative efforts designed to educate families and adolescents so that responsible decisions can be made.

I look forward to hearing from the fine panel of witnesses we have here today, about the various demonstration programs research initiated. I know in my own State, in Fort Dodge, Iowa, the Lutheran Family Service which provides adoption services, developed numerous public service announcements for radio and television under the AFL Demonstration Program. Geared toward the pregnant adolescent, these ads show that its OK and an act of real love to give a child for adoption, they show adoptive family life as positive; address the fears of the pregnant adolescent, that giving up a child for adoption is not abandoning or hating that child; another ad addresses the needs and potential fears of the child—he may ask "Why was I rejected?" The Lutheran Family Service believes strongly they provide a needed service and has enjoyed the support and efforts of the administration. If I may quote "Working for the administration has been 'par excellence.' "

Mr. Chairman, thank you for holding these hearings and for your untiring efforts as chairman of this subcommittee. I lend my support and cosponsorship to what would result in responsible legislation.

Senator DENTON. Can you tell the subcommittee briefly about the grantees' experience with the parental consent and family involvement requirement? Have you received reports on cases when families have not been involved, as required by the law, and can you provide us with examples of successful models family involvement, after parental consent has occurred?

Dr. BRANDT. We can provide you with detailed descriptions of some of these projects if you wish, Mr. Chairman. Reports from the grantees so far suggest that the parental notification and consent requirement is workable, and has posed relatively few problems. Forty-four of the fifty grantees reported no problems at all in implementation. Four grantees reported 3 percent of clients, who were young people, who did not continue, and two grantees reported 5 and 6 percent, respectively. So at this point in time, only six projects have reported any people who did not pursue services due to the parental consent requirement.

Mrs. MECKLENBURG. I would like to add that we have a number of ways of involving the family in the programs offering care services and prevention services. These models are being tested, and I think it is very exciting to realize the variety of ways in which families can become involved after the consent occurs.

I would like to just give you some general ideas of those methods and any specific examples for any grantee, we would, of course, be happy to provide for the record.

In the area of care services, we have grantees who are providing family counseling, and who work with the entire family when they see the serious problems that affect the teenager and the pregnancy. The parents and male partners are encouraged to attend prenatal classes, and they do in many instances. Both the parents and the male partners receive information about adoption in many of our programs. Parents participate on advisory boards and are involved in the development of curriculums in projects.

In some of our programs, parents and adolescents attend classes together in dealing with the area of sexuality. In some cases, they receive separate classes, but they are encouraged to communicate back and forth with one another about the subject matter, and actually may do homework assignments together.

We have parent and grandparent support groups in various projects. The staff may contact family members in very many different ways to invite them into the program, and they may conduct home visits and actually be present in the home situation in order to help the adolescent and the family more effectively.

Supportive counseling is available to families on an ongoing basis. Sometimes referrals are made when necessary to other specialized facilities—for example, they may be psychiatric facilities where chemical evaluation and treatment can occur. All these types of family involvement occur among the various grantees offering care services.

In the prevention area, the curricula often stress parental involvement in family life and sex education of adolescents. These projects strive to enhance the quality of family relationships in the curriculum and in the teaching. They may have seminars for parents and teens or meetings of parents. When children are taught in a day school on a regular basis, the project staff will invite parents to attend an evening meeting so they will have an opportunity to talk with the parents about what their children are learning in the classes. Often, these meeting are held in the evenings for the convenience of parents to encourage them to attend.

Overviews of the curriculum and other materials are sent by mail to parents. There are presentations in the community, presentations to PTA's and school boards, and group meetings with parents whose children may not be affected by the problem yet, but who certainly are interested in trying to prevent this with their adolescents in the future.

Many of the schools where the curriculum has been presented, have parent advisory groups; these groups provide the parents with an opportunity to have very concentrated involvement in the program.

These are some of the ways the AFL grantees are involving parents I think it is going to be very exciting to see how interested parents are and how their involvement can make a difference in the outcome in this serious problem.

Senator DENTON. Thank you.

I think we have some distinguished guests here, whom I believe deserve recognition. I am told that there are several members of the Parliament of Thailand in the audience. How many of you are here—would you please raise your hands?

We would like to extend a cordial welcome to you and thank you very much for coming into our houses of legislation. You are wonderful allies and friends, and we greet you.

The law requires decreasing Federal funds over 5 years for projects. The State and community role will be essential in the continuation and success of ongoing AFL projects. What has been the indication that there will be sufficient local financial support to continue beyond the Federal funding? What has been the non-Federal response to date?

Dr. BRANDT. Today, Mr. Chairman, at least in fiscal 1983, over 40 percent of total funding—and, just to be precise, 41 percent of the total cost of these projects—have been borne by non-Federal funds, including State funds, county and city funds, private nonprofit funds, and foundation funds.

I think that that is an optimistic and positive showing, but I think that we have to be optimistic that this program will continue. I think that most, or at least, many local areas, certainly States, have been concerned about the issue of adolescent pregnancy for some time. We know very well that adolescents becoming pregnant tend to have a very high infant mortality rate, for example. They have other adverse consequences both to their babies' health and to theirs. Many public health workers have been trying to find successful models that would allow them to first prevent adolescent pregnancy, and secondly, try to deal with the adolescent who is pregnant in a way that will lead to the healthiest possible outcome.

So I feel very optimistic that these programs that are successful, that demonstrate a successful outcome, will be adopted by communities and by States as a method to meet this problem, and that they will be continued.

Mrs. **Mecklenburg**. Senator, I might add that another strength of this program is the strong community involvement that is required, and not only in the area of funding. As Dr. Brandt has indicated, each program must have a match from local funds; and 41 percent of the funds came from other than Federal sources. In addition to that factor, we have many grantees who are working with multiple agencies in the community in which they exist. Some of them are linkage projects, and they bring together agencies within the community in order to deliver comprehensive and integrated services.

So, by their very nature, these programs have already involved the community. The firsthand experience of those agencies would encourage them to have an ongoing commitment to see that those services continue to be provided and available to pregnant adolescents and to parents and children in the community.

So I think the program is well-designed to help make us feel optimistic that programs will continue in the communities in which they are started, and in fact, be picked up by other communities as successful models.

Senator **Grassley**. Mr. Chairman.

Senator **Denton**. Yes, Senator Grassley.

Senator **Grassley**. At this point, it might be good for me to bring in another form of interaction. If this has not already been discussed, then I will read it in the record so you do not have to repeat yourself, but I was wondering along the same line to what extent the Adolescent Family Life Program grantees interact and work together with family planning grantees under title X.

Mrs. **Mecklenburg**. The AFL law does contain family planning as part of the necessary care services. However, the law does not allow the grantees to provide family planning services with title XX funds, if the services can be paid for and are available from other places in the community.

From all that we can tell, what is happening is that referral and interaction are occurring between family planning service providers and our title XX programs and that seems to have been intended in the law.

Senator **Grassley**. So, there is interaction then.

Mrs. **Mecklenburg**. And referral, yes.

Dr. **Brandt**. In addition, Senator Grassley, I think again, that what we learn from the demonstration projects will be information that will certainly be made available to title X grantees, and again, since the majority of title X grants are now awarded to State health departments that, it seems to me, will allow a statewide activity utilizing the successful outcomes of these demonstration projects. So I think the real interaction will come in the future, when we gain more knowledge from these demonstration projects.

Mrs. **Mecklenburg**. Excuse me, Senator. I might add just one thing that occurred to me, that some of our grantees—the one from Pennsylvania comes to mind—are actually title X grantees as well. There are a number of health agencies, as Dr. Brandt has said, who are recipients of the title X, as well as title XX, grant moneys.

Senator **Grassley**. Is there any evidence of any friction between the two groups, or any expression of unwillingness to cooperate, that you know of?

Mrs. **Mecklenburg**. I think that many family planning people, as well as people working in this program, would prefer to see young female and young male adolescents refrain from being sexually active. And so, from that standpoint, I think there is a natural base for these people in both of these programs to work together to encourage postponement of sexual activity. I also believe that after an adolescent has become pregnant, people in a variety of programs are concerned about the outcome of that pregnancy and would like to see the healthiest delivery and outcome possible for the mother and the baby.

Senator **Grassley**. That is all, Mr. Chairman.

Thank you.

Senator **Denton**. Thank you, Senator Grassley.

I gather from your last few answers that the future, in terms of fulfilling a recognized need for sexuality counselling and sex education, with Government, through the Adolescent Family Life Program, having provided seed money to begin to be the core or the nucleus of an effort, and eventually the function and administration of those projects being turned over fully to the community, looks optimistic. You are first getting the financial interest and commitment, locally, and second, getting a functional interest, which has been generally successful.

Is that generally true?

Dr. **Brandt**. Yes, that is correct, Senator.

Senator **Denton**. In terms of community support for the Adolescent Family Life Act—I think you have already answered this—would you describe the experience with grantees' efforts to involve community, charitable, and religious organizations in the development of programs as required by the law? There may be some element of that question you would care to further elaborate.

Mrs. **Mecklenburg**. Well, one of the things that would be important as far as long term and ongoing provision of these services will be to look at the policies at the State and local level which may have an impact on the delivery of these services. And one of the things that we are planning to do is to take a look not only at Federal, but also at State and local policies, to see what kinds of policies might be supportive or might hinder the efforts that we have begun in the title XX legislation.

Senator **Denton**. Would you briefly describe the process used by the Office of Population Affairs to solicit applications and to award demonstration grants. Can you tell us what the objective criteria are?

Mrs. **Mecklenburg**. The demonstration grant process in the Office of Adolescent Pregnancy programs is quite similar to procedures used in other programs that have a similar kind of mission. An announcement is made in the Federal Register, informing the public that applications are being requested. In addition to this announcement, because we want to be sure that everyone possible knows about the fact that we are soliciting applications, our office sends a copy of that request for proposal when those applications are open to every individual and organization who has requested this information.

Then, an application kit, which contains the law, the actual forms that are used, and instructions on how to apply, is sent to every person who inquires as a result of hearing about the applications being opened. A professional review of all applications is made. This review utilizes the objective criteria that are made available to the applicant in either the request for application or the application kit. It is very clear what the criteria will be, and applicants are aware of what the objective criteria are prior to submitting their proposals.

The experts conducting the reviews are outside the office of the Office of Adolescent Pregnancy Programs. Since a variety of services and models is called for in this legislation, reviewers possess relevant, but varied experience and expertise. Readers have expertise in the fields of adolescent pregnancy prevention and care services, youth services, family life, child and adolescent development, day care, and related fields. They also represent the public and private sectors, universities, voluntary organizations, and religious and charitable institutions. The program director then utilizes the scores and information from this professional review and the published objective criteria to decide which applications are funded. After the final decision is made, a notice of grant award is prepared by the Grants Management Office and sent to each successful applicant.

There are a number of objective criteria taken into consideration during the grant review process. Some of the factors that are included are the capacity of the applicant to provide the appropriate services and evaluate the results; the project objectives and the methods for achieving them; the innovativeness of the program approach, its worth for testing and replicability; its suitability to measurement and evaluation; the population to be served, and the usefulness for policymakers and service providers of the proposed project and its potential for complementing the existing Adolescent Family Life demonstration projects.

These are just a few of the published criteria that are utilized in that review process.

Senator DENTON. How much difficulty did being unsure that you would have an appropriation for the administration of the Adolescent Family Life Act present you? Mrs. Mecklenburg, from your point of view, as I recall, it was late in calendar 1982 before you had word of appropriation. What impact did that have on your planning and administration at a time when you were just beginning to implement the act?

Mrs. MECKLENBURG. Well, one had to take into consideration the situation and look for a review process that was a good review process, but that could be accomplished in the situation where we did not know for certain whether we would be able to fund any programs. In addition, we did not have a budget, so the Department was very cooperative in helping forward-fund us so that we could begin the review process, and then be able to be in a position to award grants once the money was received, if it were to be received. So we worked with the situation and were able, I think, to conduct an excellent review process and be in a position to actually award the grants and get the program well under way, even though we had funding coming late in the fiscal year.

Dr. **Brandt**. I think, Mr. Chairman, it is important to point out at this stage and to thank many of the grantees, who had a great deal of confidence that this activity would come to fruition and funds would be made available, and actually went to work preparing grant requests, doing all the necessary work, without any real assurance that anything would come from it. And I think that those people are clearly committed to the concepts embodied in this act, and demonstrated that very clearly by working hard before they knew whether or not any of those plans would be carried out, so that I think they deserve a great deal of gratitude and commendation for their confidence in the system.

Mrs. **Mecklenburg**. I have to agree. There were over 400 grant applications, from people who were that concerned and that interested in the program. I think that is a real vote of confidence.

Senator **Denton**. How does the Office of Adolescent Pregnancy Programs monitor grantees for their adherence to the principal requirements and restrictions of the law?

Mrs. **Mecklenburg**. We use a variety of mechanisms to monitor grantees routinely. Again, this is in keeping with the system used in the Department in other programs. Each grantee has a project officer, who is primarily responsible for monitoring both the progress and the performance of each project. This includes monitoring the items included in the law, and all of the things that we would be concerned with in an oversight capacity.

They use monitoring techniques such as phone calls, surveys, written reports from the projects, grantee meetings, face-to-face meetings with the grantee and the people working in the projects, and site visits. Also, we review project material and other materials in the office for their appropriateness and their usefulness in the project.

If any potential problem is found in any area, complete information regarding the issue is obtained from the grantee. It is important to get all the information and get it accurately in this situation. We then review the specifics of each situation. When necessary, we consult with other units in the Department—for example the Grants Policy Office or the general counsel. Then, when we have some guidance to give the grantee, we are able then to tell them what changes are required to ensure conformity with the law or policies of the Department. We communicate that to the grantees and work with them in order to get the changes that might be required.

Senator **Denton**. Well, thank you very much. Unless Senator Grassley has any further questions, and unless either of you have anything you would wish to add, I want to thank both of you for your excellent testimony here this morning.

Senator **Grassley**. My last question would be based upon the presumption that many of the organizations that would apply and receive grants and be demonstrating and researching in this area maybe previously were conducting some work in this area, and may philosophically be aligned. If that presumption is wrong, then the basis of my question would be wrong. But to the extent to which that may be a correct presumption, to what extent, then, is the efforts of this program directed toward new activity and an expansion of existing activity that would not otherwise occur as a result of a previous private sector determination to do these things?

Dr. **Brandt**. I think that it is largely new activity, Senator. In the first place we have, I think, 19 research grants, that clearly were work that was not being done, and that will contribute.

I think the projects that were funded were selected by using the criteria Mrs. Mecklenburg has already specified, one of which was to pick those that had the most innovative approaches to trying to either prevent adolescent pregnancy, on the one hand, or to care for the adolescent teenagers, on the other hand.

Now, you are absolutely right that many of the people involved in this program have been people who have been concerned with this problem for some time, and have experience in dealing with the problems, and could bring that to bear in a totally organized demonstration system, that will allow for appropriate evaluation and allow for the kinds of modifications that may be mandated by evaluation and that could then be adopted by other people who may not have the same degree of experience and sophistication.

So I think what we are seeing is a new approach based upon old principles and old experiences, if you will, that has allowed a focus of attention and a focus of care that we probably would not have seen without this program. My guess is we would not have seen it.

Senator **Grassley**. Well, I appreciate that very much. I want to say that I know that Iowa's grantee in this area has enjoyed working with the administration on the things that they have set out to do and that you have OK'd their doing.

Let me just follow up, then, as kind of a preface to my last question. Did the administration, HHS, or any other department involved, make a survey of private sector involvement in this area before we set out to request grant applications?

Dr. **Brandt**. No; we did not do a formal survey. I think what we did recognize, Senator, was that clearly, the number of adolescent pregnancies is growing, in spite of efforts that have been initiated around the country to try to stem that increasing tide of pregnancies, that the infant mortality rate due to teenage pregnancies was high, and that something needed to be done, and therefore, it looked like it required a new approach, at least a new look, at the whole problem. So that I do not think you would call what we had available to us a formal survey around the country, but we did have a lot of information about things that were going on and about some possible ideas.

Mrs. **Mecklenburg**. Senator, I would like to comment on the fact that there was a title VI program, the precursor to this program, which gave people some experience in the whole area of adolescent pregnancy at the Federal level. The title VI program also commissioned a national study of teenage pregnancy programs around the country in order to identify the kinds of programs that were being provided in various communities. That study is completed, and we would be happy to send you a copy.

Senator GRASSLEY. Was that completed prior to our starting this title XX program?

Mrs. MECKLENBURG. No; but the work was ongoing.

Senator GRASSLEY. So you did have a source of research available.

Mrs. MECKLENBURG. Some notion, anyway. And I wanted to comment about your previous question. I think that one of the strengths of this program, is the evaluation component. What we had seen around the country were a number of efforts that had been undertaken in the area of adolescent pregnancy by service providers. Many of them were attempting, very successfully, I hope, to cope with that problem. But evaluation of their efforts was not part of the program. It is very unusual for service providers to have the opportunity to evaluate their results in a rigorous way. It just does not occur without an emphasis that this program presents.

So, although we were aware, through the JRB study that was commissioned, through knowledge obtained in title VI, and through talking with foundations and people around the country, that indeed there were efforts underway, there was no program to look systematically at those efforts and to evaluate which ones were going to intervene most successfully in this problem. So I think that evaluation is one of the real strengths of the title XX approach.

Senator GRASSLEY. OK. At this point in the program, where we are ready for reauthorization—that is the issue, to move ahead—is there anything that you have learned thus far that should not be repeated—any negatives that would come out that you would say are things that we have learned that we should not—I do not know how else to say it other than just to say—we will not repeat. I mean, you have positive things you have talked about. I assume that there is a large base of information that is still in question. You are waiting for more research. But as we move into the third year, is there anything you have learned that should not be repeated?

Mrs. MECKLENBURG. Well, Senator, the programs have actually been functioning now for 18 months. It is still a bit early, to know in any definitive way, what works and what does not work. Experience in demonstration evaluation models would indicate that you need a longer period of time to get the services underway, to collect client data, and then, to analyze that data.

Senator GRASSLEY. So it is too early?

Mrs. MECKLENBURG. It is really too early. Now, obviously, one of the purposes of this program is not only to look at what does work, but also what does not work. So we would expect to have some answers on that side of the ledger.

Senator GRASSLEY. Do you see any trends of what does not work?

Mrs. MECKLENBURG. No; I think at this point, I can say that it appears that the results that we have gotten so far are very positive results, in general. But I must caution again and say that these findings are only preliminary, and we could not make final judgments yet.

Dr. **Brandt**. I do think, Senator, though, that it is important to emphasize that there have not been any glaring weaknesses that have shown up at this stage of the game, and that gives us confidence that the kinds of weaknesses and the kinds of problems that we find are more likely to be subtle and amenable to change than what sometimes happens in the early days of a new program.

Senator **Grassley**. Thank you.

Senator **Denton**. I am very appreciative of the thrust of Senator Grassley's question. I would ask if, considering the tardiness of the 1982 appropriations, and the fact that projects are no more than 18 months old, is it unusual for demonstration projects not to have definitive evaluation results upon which to make firm statements to serve as confidence factors for those who would reauthorize the bill?

Dr. **Brandt**. No, sir; not at all.

[Responses of Mrs. Mecklenburg to questions of Senator Denton follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

Fil.

1984 SEP 28 PM 1:20

SEP 27

The Honorable Jeremiah Denton
United States Senate
Washington, D.C. 20510

Dear Senator Denton:

Thank you for your letter requesting responses to questions related to the Adolescent Family Life Act.

Enclosed as you requested are the responses for the written record.

I hope this is helpful. If I may be of further assistance, please let me know.

Sincerely yours,

Marjory Mecklenburg

Marjory E. Mecklenburg
Deputy Assistant Secretary
for Population Affairs

Enclosure

1. QUESTION: Please provide for the record the number of clients who have been served under the AFL care projects and under the AFL prevention projects.

ANSWER:

° Care Clients:	1st Year Total	24,000
	Pregnant adolescents, teen mothers	8,500
	Infants	3,100
	Male partners	1,800
	Family members	10,600
° Prevention Clients:	1st Year Total	35,000
	Parents	8,500
	Adolescent Males	10,100
	Adolescent Females	16,400
° Prevention-trained Counselors:	1st Year Total	4,300

2. QUESTION: Please provide for the record a breakdown of funds expended for prevention, care, and research under the AFL program.

ANSWER:

° Care Projects	$4,787,123
Combination Projects - Care Services	$2,099,179
Total - Care Services	$6,886,302
° Prevention Projects	$2,131,045
Combination Projects - Prevention Services	$1,233,759
Total - Prevention Services	$3,364,804
° Research	$1,742,716

3. QUESTION: What are your current plans for coordinating the evaluation projects of the grantees? How will the evaluation be able to show what has been "demonstrated" and what should be replicated?

ANSWER:

Title XX requires that each individual project is responsible for developing, maintaining, and evaluating detailed information about its operations and clients. These evaluations are being completed with the assistance of faculty members from a college or university in the state where the AFL project is located. The Office of Adolescent Pregnancy Programs (OAPP) approves the individual project evaluation plans, and OAPP staff work with local evaluators whenever necessary. The office has awarded a contract to provide technical assistance to the grantees in the area of evaluation. The office has also sponsored a series of workshops for the evaluators and project directors.

In addition, OAPP has awarded a contract to develop a cross-cutting evaluation design. This design will analyze data from 43 projects offering care services to pregnant and parenting adolescents. This cross-cutting evaluation will not duplicate analyses from individual evaluations; by pooling data on the characteristics of clients, services obtained, health and social outcomes for mother and child, this evaluation will show the impact of different amounts and types of care services on individual clients and on various subgroups of clients. Following the completion of the cross-cutting evaluation plan in FY 1984, a national evaluation contract will be awarded for FY 1985 to implement this design.

Finally, a cluster evaluation methodology will be utilized to evaluate several projects which share some common components of national interest. A national evaluator, under contract to OAPP, will design and conduct cluster evaluations on characteristics that certain AFL projects have in common. By collecting data on these characteristics and relating them to outcomes and other program data, the national evaluator will be able to determine the effectiveness of various services.

Senator **Denton**. Well, thank you very much, Dr. Brandt, and thank you, Mrs. Mecklenburg, for your testimony this morning.

Senator **Denton**. Our next witness is Sister Mary William Sullivan. I will tell you more about her as she approaches the table.

First, I would like to say for her and for all other witnesses, the subcommittee has quite a few witnesses this morning, and there is another hearing scheduled in this room at 2 p.m. Hopefully, we will not have to tax our skill to get out of here before then. But in the interest of time, I must insist that the witnesses constrain their overall remarks to 5 minutes. Your written testimony will be included in the record in full, and I want to thank all of you in advance for your cooperation.

Sister Mary William Sullivan is the supervisor of Adoption and Maternity Services at Catholic Family Services of Amarillo, TX. She is accompanied by a young lady, Christy, who participated in the Catholic Family Services Care Project.

At this time, for reasons relatively obvious, I would ask the cooperation of the television cameras. If you have filmed Christy from in the front of her, I would ask you not to show that film. I would appreciate you filming her from behind. And the same request would be made with regard to another young lady who will testify later, Heather, who will testify with Mrs. Peggy Sanchez of the St. Petersburg YWCA, and I trust the television people will cooperate.

I welcome you, Sister, and Christy, to Washington. And Sister Mary Sullivan, if you have a prepared statement, we are ready to receive it.

STATEMENT OF SISTER MARY WILLIAM SULLIVAN, SUPERVISOR OF ADOPTION AND MATERNITY SERVICES, CATHOLIC FAMILY SERVICES, INC., AMARILLO, TX, ACCOMPANIED BY CHRISTY, PARTICIPANT IN CATHOLIC FAMILY SERVICES CARE PROJECT

Sister **Sullivan**. Thank you, Senator Denton.

We wish to express our gratitude for the opportunity to come before the Subcommittee on Family and Human Services to tell you the good news.

Our program really got underway, finally, December 1982, and people from Texas do things in a big way, so we took on all three of the different components—the sexual education for teenagers and their parents. This has been very, very successful. We have had 263 sessions and 430 hours of work with 2,320 adolescents and their parents, in various symposiums and workshops. It is quite interesting, Senator. We find that the questions the young people pose at the beginning—they write them on cards—are everything from where do babies come from to very complicated questions concerning babies, intercourse, sexuality, and so on.

In having these discussions and presenting this information in which we use audiovisuals, as well as questions and answers, we find these young people very often have a very lopsided attitude and do not have complete information concerning this great power and wonderful ability they have to express their sexuality.

They also have conferences and workshops with parents. The parents have expressed overwhelmingly their feeling of total powerlessness in the face of mass media, television, movies, and so on, and presenting sex as something that should be indulged in without any sense of responsibility, but just a response to their own feelings.

In evaluating these sessions, the parents have been really grateful for the help they have received in communication with their kids, as they say. And the young women who have participated in the symposiums have expressed that they really feel better about the fact that they do have a choice of being sexually active or not, and they can make that choice, and they can state it.

Interestingly enough, the young men are often amazed at the physiological phenomenon of pregnancy and childbirth. It seems like we educate the young women to that, but not the young men. And when the young men see this and realize that this is a part of them and a part of what they have procreated, they stand in a great deal of awe.

In this case, we have only just begun, because these one or two sessions are not enough in dealing with these youngsters. They go and they process it, and they talk it over, and they have to come back.

Having these sessions with their peers is extremely important, because that is very often where much of the pressure comes for early sexual activity.

We feel that we need the opportunity for offering available correct information to young people and their parents, since their major source of information now comes from mass media and R-rated pictures, and offering opportunities to check old wives' tales in a nonthreatening atmosphere, where the old stereotypes come up, and these are dealt with in a very direct and honest and frank way, and the open discussion of sexual matters in the company of one's peers, as well as in the company of adults. Some of our sessions have the youngsters and the parents apart, and then we bring them together for the open discussion. And the more you can do this, the more you get it out from behind the barn, and you bring it out as something that can be discussed with great respect and making them comfortable. We feel this is a great plus.

In addition, we now have 46 counties, and we are going to add 5 more. We have television spots, we have billboards. We give free pregnancy testing. We have had 186 pregnant adolescent girls, 75 percent of whom are under 18 years of age, and we have talked to them and counseled with them. Their presenting problem, they come to us most often with: "How am I going to pay for this?" I think that the whole thing that is brought up in terms of working with Medicaid and working with other programs to assure good prenatal care for these young women is extremely important, and we work with them on that.

We also offer counseling. When we say adoption is an option—and we have had those billboards around—it is a loving option. It has to be seen as an option, and options mean there are other choices. So, the young women have to have an opportunity to know what those are, because they will live with those decisions the rest of their lives. We say to them, "Whatever decision you make is hard, and let's look at the consequences." In order to help them, we have opened a maternity home for eight young women.

To bring this all together, though, Senator, I feel that perhaps the best way would be—I have asked one of the young women who has participated in our program to make a statement to you, and hopefully, this will enflesh what we have just said.

Christy.

CHRISTY. I would like to talk about the care I personally received from Catholic Family Service, Inc.

When I first went to Catholic Family Services, I wasn't at all for adoption, and it took me up until I was almost due to realize that adoption was a loving option.

I was assigned a caseworker my first visit. We talked a lot about both options. She never pressured me on either one. I was told it was my own choice.

Through her and Catholic Family Service, I was placed in a foster home because of problems my mother and I had. There, I was able to think things through without pressure. I was part of a stable family and treated with kindness and understanding. I felt in a way I belonged. I loved them because they acted like I was their daughter and not just a house guest.

I was provided with a doctor that saw to it that I had a healthy baby and that I took care of myself. My caseworker always made sure I was there for my appointments. The doctor's fee was taken care of by Catholic Family Service, because I was not able to.

I was given a counselor to talk to. He got to hear all of my problems. We talked once a week. He helped me weigh pros and cons and also take a look at my options. He talked with my mother and helped us see eye to eye. I was very grateful to have him, because he helped me see myself more clearly, and got me going in the right direction.

When Catholic Family Service Residence opened, I went there. Everybody was like one big family. I made a lot of new friends and was able to relax. Everybody treated everybody with respect and kindness. There was always a shoulder or two to cry on, and your own room, if you just wanted to be alone. They were all so helpful when I went into labor, it really meant a lot to me.

There are just a couple of more things I would like to say. First, Catholic Family Service was the best adoption agency I could have chosen. They provided me with the best care possible and, thanks to their loving kindness and understanding, I have a very healthy baby and a strong mind that knows which direction to go from here.

Thank you.

Senator DENTON. Thank you, Sister Sullivan, and thank you, Christy.

[The prepared statement of Sister Sullivan follows:]

Catholic
Family
Service, Inc.

Diocese of Amarillo

Bishop of Amarillo
L. T. Matthiesen
Katie McDonough
Executive Director
Mike Matteo
President
Betty Tellman
Vice President
Donna Moore
Secretary
Tony Salazar
Treasurer
Rev. Jacinto Alderete
Dr. Robert Beckley
O.M. Calhoun
Dr. James R. Carroll
Edward M. Dunigan
Pat Fish
Dr. John Green
Selden Hale
Lois Hull
John Jackson
John Kratochvil
Carl Looten
Jim Murphy
Dee Ramirez
Rev. Joseph Tash
Pete Valdez
Odile Zientek

ASSOCIATE MEMBERS
Joyce Cross
Ann Herrick
Eveline Rivers

We wish to express our gratitude to Senator Denton and the Committee on Family and Human Services for giving us the opportunity to present our story. It is the story of young people who are living in a world of sophisticated sexual mores with which they are bombarded constantly.

Catholic Family Service of Amarillo began its program of Adolescent Pregnancy Care and Prevention in December, 1982. Our first goal is "prevention of adolescent pregnancy and support to adolescent parents." The objective states more succintly the direction the program has taken in the sixteen months of its operation: "to find effective means within the context of the family, of reaching adolescents before they become sexually active, in order to maximize the guidance and support available to adolescents from parents and other family members, and to promote self discipline and other prudent approaches to the problem of adolescent premarital sexual relations, including adolescent pregnancy." A curriculum in the form of workshops and symposiums is offered to groups throughout the Panhandle area. In preparation for this, staff members contact teachers, ministers, persons who have a vested interest in working with young people and their families.

Amarillo, Texas 79101-4199 1522 South Van Buren 806-376-4571 ACCREDITED

Catholic Family Service has conducted 263 sessions, 438 hours of workshops reaching 2,320 adolescents and parents.

The young participants were asked to write any questions they had regarding sex, sexuality, intercourse, pregnancy, etc., on a card. The questions are an enlightment in themselves:

"If you have an abortion, can you still have a baby later?"

"Where do babies come from?"

"What is oral sex?"

"Can a man and woman have intercourse if she's pregnant?"

"If you have sex do a woman always have a baby?"

"What happens if you are pregnant from a relative? Would your baby be deformed or mental?"

"Is it wrong to get a girl pregnant and then leave withour telling her and letting her raise it by herself?"

Our presentations cover information, attitudes, and frank discussions of "myths".

We also offer workshops for parents' groups. The parents are asked to write their concerns on a card anonymously before the session begins. Parental concerns are:

"The message they receive from TV and songs on the radio is'sex equals love' (that just not true). The songs don't mention the consequences--divorce, sexually transmitted disease, danger to a young mother and child."

"How much does my teenager know of and about sex? Is it correct knowledge or is it incorrect knowledge?"

"Worried about too much TV. My son is sixteen and watches too much TV."

"I worry about other teenagers and their influence on my teenager about sexual ideas."

In evaluating these sessions, the parents most frequently state that "help with communicating with my kids" is the greatest benefit of the discussions and presentations. Among the teenagers, the evaluations run everywhere from "finding out the difference between sex and sexualtiy" to "the neat feeling of a baby growing inside you and how beautiful it is."

It is interesting to note that the greater majority of the young women involved state their new awareness of "I have a choice and can control the expressions of my sexuality." The young men state a new awareness of the physiological processes of pregnancy and birth. Having the opportunity for open discussion with significant adults and with their peers takes some of the "behind the barn" mystic out of the truly beautiful and natural power that is theirs.

Along with our workshops and group sessions we run public service announcements offering pregnancy testing, counseling, etc. We have many unidentified callers who ask an unimaginable number of questions! The staff doesn't pressure, but attempts to answer their questions honestly and sensitively.

WE'VE ONLY JUST BEGUN! Each opportunity to present materials and discussions heightens our awareness of the great need for:

1) availability of correct information to young people and to parents; the major source of information now comes from mass media and R rated pictures.

2) offering opportunities to check out "old wives' tales" in a non-threating atmosphere;

3) open discussions about sexual matters in the company of one's peers.

We see a need for the follow up contacts and sessions. It is just too much to cover in one or two sessions. Young people need to process information, feelings, attitudes. We are facing the Goliath of multimillion dollar media presentations that communicate a distorted picture of sexuality, its purposes, its rewards and its responsibilities. Our young people have a right to correct information. We will offer follow up sessions with some of the same groups as well as to meet with new audiences. We see the need to offer individual counseling as part of the sessions. Parent support groups are needed to help adults gain the skills to discuss with their teenagers the facts and fictions about sex and sexuality.

In addition, as word gets around the community(Catholic Family Service services forty-six counties in the Panhandle of Texas), more inquiries are being made. Five more counties are being added to our service area inJune. We are working on expanding our audio-visual materials, brochures, bibliographies to meet the needs of the broader and diverse community. We have printed and processed materials inSpanish for the many Hispanic groups in the service area. We have presented our program to staffs of juvenile detention facilites, health and education groups, ministers and a variety of volunteer organizations.

Our second goal is "to promote adoption as an alternative for adolescent parents." Social pressure and social acceptance have increased the number of abortions performed on adolescents to an alarming degree. As one young woman said, "It looks like an easy way out, but it isn't." When a young woman chooses not to abort a child, there is often pressure for her to keep the child and this forces her into the assumption of early adulthood.

Young woman who choose to carry their child full term and place their baby in the hands of a couple approved for adoption must make a decision with as much freedom, information and support as possible. Over the program period we have selected, and hopefully strategically placed, ten billboards with the caption "Adoption Is A Loving Option ." During the past sixteen months, we have counseled and worked with 186 pregnant adolescent girls, 75% of whom are under 18 years of age, to help them obtain good medical care. Group sessions have been conducted to deal with the reality of sexuality, pregnancy, child birth and care, budgeting, career planning, etc.. We have met with 27% of the alleged fathers in counseling. The reason for the non-involvement of many alleged fathers is often:

> "It's not my kid!"
>
> "It's her problem. She should have taken care of herself."
>
> "I can't support anybody!"
>
> "I didn't even know her. I just met her at a party and we were drinking...."

We believe that it is imperative that each young mother (and father) has the opportunity to be exposed to all the options for the child. We provide these options through individual counseling, written material group sessions and a living arrangement to enable the decision to be made after all the options are looked at.

The third goal of the program is "to establish innovative, comprehensive, integrated approaches in the delivery of care services for pregnant adolescents, with primary emphasis on unmarried adolescents who are seventeen years of age and under, and for adolescent parents."

The ethnic diversity of our adolescents has directed the way we present material and the way we offer counseling. 15% are Black, 32% are White, 53% are Hispanic. 11% are under fifteen, 64% are fifteen to seventeen, 25% are eighteen years of age. Our program provides assessment and appropriate service plans for either prevention or pregnancy services to the adolescents. Preganancy tests, counseling casework, legal services, adoption services, pre and post-natal care, VD screening, homemaker services, child-care arrangements and family planning are offered to these adolescents.

In working with pregnant young women, we find that many of them need an opportunity away from their own home and parental ire, as well as away from the pressure of their peers. On February 1, 1984, we opened a maternity residence with the capapcity for eight young mothers. The young women range from twelve to nineteen years of age. The goal of the program is to provide a caring and nurturing milieu for young women to allow them the support and freedom to make life decisions for themselves and their child. One young woman stated, "I realize now that I couldn't make a decision at home. Everyone tried to be so kind and supportive, I guess I was drowning in love. I didn't realize it until I came here to the Residence and saw so many kids whose families had thrown them out and told them it was their problem. Now I know my decision is right for my baby and me. The peace and privacy here really helped."

There is close coordination of service agreements with many of the health and education agencies in our immediate area. The cooperation of these human service programs has been most encouraging and supportive. As we move in to the next phase of our program, we are more aware of the great need for the various facets of agencies, programs, and organizations which we are encompassing in our program with adolescents and their families.

We at Catholic Family Service of Amarillo strongly urge the Committee to approve the re-funding of the grant for the next three years in order that the gains that have already been made will not be lost because they have not been able to be reinforced by follow-up or extended to others whom we had not been able to reach in so short a period. The investment in the lives of this generation and of future generations is in many ways priceless. Our young people and their children have the right to the freedom of truth and responsibilities. They are not getting either through much of our present day mass media presentations. But there is great hope.

Thank you for the opportunity to share the efforts and positive results of our work. It is hard but it is so worthwhile.

APPENDIX

TESTIMONY OF A PROGRAM PARTICIPANT

I would like to talk about the care I have personally received from Catholic Family Service, Inc.

When I first went to Catholic Family Service I wasn't at all for adoption and it took me up until I was almost due to realize that adoption was the loving option. I was assigned a caseworker my first visit. We talked a lot about both options. She never pressured me on either one. I was told it was my own choice.

Through her and Catholic Family Service, I was placed in a foster home because of problems my mother and I had. There I was able to think things through without pressure. I was part of a stable family and treated with kindness and understanding. I felt in a way I belonged, I loved them because they acted like I was their daughter and not just a house guest.

I was provided with a doctor that saw to it that I had a healthy baby and that I took care of myself. My caseworker always made sure I was there for my appointments. The doctor's fee was taken care of by C.F.S. because I was not able to.

I was given a counselor to talk to. He got to hear all my problems. We talked once a week. He helped me weigh pros/cons and also take a look at my options. He talked with my mother and helped us see eye to eye. I was very grateful to have him because he helped me see myself more clearly and got me going in the right direction.

When the C.F.S. Residence opened, I went there. Everybody was like one big family. I made a lot of new friends and I was able to relax. Everybody treated everybody with respect and kindness. There was always a shoulder or two to cry on and your own room if you just wanted to be alone. They were all so helpful when I went into labor, it really meant a lot to me.

There is just a couple of more things I would like to say. First, C.F.S. was the best adoption agency I could have chosen. They provided me with the best care possible. And, thanks to their loving kindness and understanding, I have a very healthy baby and a strong mind that knows which direction to go from here.

Thank you.

Senator DENTON. At this point, I think it would be worth reviewing some statistics which we have not previously mentioned. In 1981, we know of 527,000 babies born to adolescents 15 to 19 years of age, and over 9,600 born to teens under 15 years of age. When you consider that 40 percent of the pregnancies of people in that age group ended in abortion, you can just about double the 527,000 number to arrive at the number of conceptions of teenage, unmarried people. Then, when you think that only 4 percent of the babies who do survive to delivery are adopted, you begin to get a sense of the importance of what Sister Mary Sullivan and Christy are dealing with. She has, in her prepared statement, only one capitalized sentence. She discusses the problem of adolescent pregnancy and what they have been doing about it, and then she says, in capital letters, "We have only just begun!" She then mentions some of the factors that are causing this increase in sexual activity before marriage which were emphasized by Dr. Brandt and the difference in statistics between 1971 and the late 1970's. It is rather striking. She mentions the mass media and R-rated pictures as being the major source of information on sexuality, of the ideas transmitted to young people, and of role models projected.

I noticed that there was a representative from New Republic magazine here. The executive editor, I believe, Morton Kondracke, suggested that our President contact Hollywood and see if he could not do something about their propensity to oversex America. I agree with the general meaning that he had. I am not sure that what is being done is oversexing, but rather is mixing us up on sex. I am not sure that the media's message increases our joy. I think there is a large increase in pain and suffering, and perhaps, a forfeiture of some love.

But in my job of trying to promote the general welfare, I would be a hypocrite, were I not to note that I think there is something that needs to be done, albeit voluntarily, not necessarily by legislation, but needs to be done to reverse the trend that what children read and see in movies or on television communicates that the only real fun sex is that which is outside of marriage. That is a lie, to begin with, and second, it does not promote the general welfare, in my view. I think something needs be done to reverse this trend, so that the media would convey a message to the public that would contribute to the pursuit of happiness of individuals and the survival of this Nation.

Christy, you mentioned that your mother and you had problems and that as a result of the counseling provided to you by the Catholic Family Service, the counselor was able to bring you and your mother together and see eye to eye. This is something new to me. I never thought about the counseling service being provided, which gets the parent and child together on better terms than before.

Can you tell us a little more about how you and your family were able to work through a very trying situation?

CHRISTY. Well, David, my counselor—first he took my mother and talked to her, and then he got us both together. And there was a lot of crying and tears and yelling and screaming. But through him, he was able to get us both to sit down and talk to each other, which we were not doing; we were not even on speaking terms there for a while. And he——

Sister **Sullivan**. We prayed a lot.

Christy. Yes.

Sister **Sullivan**. They are cut out of the same cloth, Senator, both of them, but underneath it all, there was a great desire for unity, and they had to get some healing. So Dave would take one to lunch, then take the other to lunch, and then they would get together and talk about it.

So we sat down, the caseworker, the counselor and myself, and Christy's mother, and we were able to, between the two of them, point out the things that they had that they did not want to lose, and one was their love for each other, and also, to articulate their fears.

The pregnancy was just one part of this. Pregnancy does not just come as an isolated thing. There are many other things, and that is why we think it is so important that the counseling is available, not just around the pregnancy, but about the whole interpersonal relationships of this young woman with the young man, with her parents, and so on.

Christy and her mother are made alike, and they really do have a wonderful streak in them, and they were able to overcome their differences, so much so that her mother was there when she delivered, and that was a big help to Christy. So they both know a lot more about themselves and about how important they are to each other. But that was the counseling dimension that we would not have had, if we had not had this grant.

Senator **Denton**. Christy, you really made two decisions: one, to carry your baby to term rather than to abort, and second, to put your baby up for adoption.

Christy. Yes.

Senator **Denton**. Would you sketch the steps or the rationale by which you reached those two decisions? What were the important stepping stones to the decision to carry your baby to term, and then second, to put the baby up for adoption?

Christy. Well, the first decision not to have an abortion was my mother and I, neither one of us believe in it. So we went to Catholic Family Service, and I was not for adoption, but I thought, well, we will see what happens. And as time went by, I got to thinking that I could not provide my baby with a stable home; I would not be able to provide it with the care that it needed or—I would be able to provide it love, but that would be all I could give it was my love. So I decided the best thing I could do for the baby was give it a loving mother and father, and there, it would have a stable home, clothes, food, plus all the love it could possibly have.

And when I delivered the baby, and I saw that baby, I was the proudest mother in the world. I was so glad that I did not have the abortion, because he was a beautiful baby.

And I know the adoptive parents now are as happy as they can be because they have him, and I was able to give him to them for a good reason and a good purpose.

Sister **Sullivan**. I can say this, Senator, that the day the child was placed, I took a picture of him, and I thought a lot about it, and I came home, and I said to Christy, "We placed your son today." And it was just a darling family, and I told her a couple of the funny little things, like when I called the mother, she kept screaming, and I told her to quit screaming so I could talk to her. But then, I gave Christy the picture of this beautiful little boy, and she cried. We both cried. And she said, "Sister Mary, these are not tears of sorry, but they are tears of joy, because now, my little boy will be loved and cared for, and that is the best I can do for him."

And I will tell you, Senator, I felt about 2 inches tall.

Senator DENTON. Well, this is phenomenal, but I think it is correct, that when I was a youth, the percentage of those who kept their children rather than put them up for adoption was the reverse of what it is now. And I must concur with you, Christy. I believe that in the vast majority of cases, although it would take tremendous inner thought, I believe the correct decision in most cases would be the one you made. And maybe it is a little out of place, but there is an old expression that, "God writes straight with crooked lines," and you might have come through such an experience.

We will, perhaps, submit questions to you in writing, and I want to thank you very much for your testimony here this morning.

CHRISTY. Thank you.

Sister SULLIVAN. Thank you, Senator.

Senator DENTON. Our next witness will be Ms. Peggy Sanchez. She is the director of Project HELP, an Adolescent Family Life Care Program at the YWCA in St. Petersburg, FL. She, too, is accompanied by a program recipient, and I will ask the cameras again to remember to refrain from filming Heather's testimony and not to film her from any angle except behind.

I am glad to see you both here this morning, and Ms. Sanchez, if you have a statement, you are welcome at this time, and I would ask you to keep it within 5 minutes.

STATEMENT OF PEGGY SANCHEZ, DIRECTOR, PROJECT HELP, YWCA, ST. PETERSBURG, FL, ACCOMPANIED BY HEATHER DAVIS, PROGRAM PARTICIPANT

Ms. SANCHEZ. Thank you, Senator.

On behalf of our board, community agencies and pregnant and parenting adolescents, I thank you for inviting the YWCA to testify for the reauthorization of the Adolescent Family Life Act.

Adolescent pregnancy programs throughout the country are confronted with the challenge of taking a devastating situation and creating an atmosphere which is conducive to the needs of the pregnant adolescent, the infant, and family members. However, limited grant awards will not allow this challenge to be attained when only a small portion of our youth and their families throughout the country are currently receiving these services.

The reauthorization of the Adolescent Family Life Act is necessary in order to continue and to expand existing programs; to allow for adequate evaluation and dissemination of the effectiveness of existing programs; to continue research in areas concerning adoption and adolescent sexuality, and most importantly, to allow for the continuation of services to our country's pregnant and parenting adolescents.

I wish to briefly discuss the organization and structure of the Project HELP Program to demonstrate that the Adolescent Family

Life grantees are in fact successful in providing core services, securing necessary community support, and carrying out the intent of the law.

Project HELP, which stands for Health, Education and Life Skills for Pregnant Adolescents, is a community effort addressing the efforts of pregnant and parenting adolescents and their families in Pinellas County, FL. Project HELP has two sites, separated by 30 miles. Combined sites provide services to 65 clients, ages 11 through 18, for an average length of involvement of 8 months. All services except medical care are provided onsite at both centers.

Project HELP is a cooperative effort administered by the St. Petersburg YWCA. It was funded and implemented under title VI funds in 1981. Currently, the program is funded through the Adolescent Family Life Act funds and multiple community agencies including juvenile welfare board of Pinellas County, city of St. Petersburg, Pinellas County, and school board of Pinellas County.

The first component of the program is academic education. It offers an alternative school at both centers which is staffed by five certified teachers. Each teacher has no more than 15 students which enables individualized instruction. The adolescent can participate in this program and obtain all of the necessary credits for high school graduation. All records, grades, and credits are transferable upon completion of the program.

The life skills component of the program is provided daily through a combination of community agencies and project staff. Onsite educational information is offered in such areas as child abuse prevention, nutrition, adoption, sexually transmitted diseases, responsible sexuality, parenting, consumer education, and career planning.

Counseling services, provided through an agreement with family service centers, include individual, group, and family counseling. The counselors monitor the client's progress, provide support and guidance, and most importantly, act as an advocate for the adolescent as she receives services in the community. Clinical supervision is provided by a certified sex therapist.

The health services, including pregnancy testing, family planning, pre- and post-natal and pediatric care, are provided primarily through the Pinellas County Health Department. Coordinated efforts between Project HELP and the Improved Pregnancy Outcome Program at the health department have resulted in the establishment of a protocol which allows for all high-risk pregnant adolescents to participate in the maternity clinic. In addition, Pinellas County Health Department has incorporated into their computer information necessary for the Project HELP staff to effectively monitor the clients' progress. Pregnancy outcome information is readily available in this cooperative agreement.

Preparation for childbirth is taught weekly to clients, fathers of the babies and family members. This service provides individualized instruction and guidance, with the realization that the average age of the project's client is only 15 years.

Child care services are available at both centers for infants under 3 months of age. Since this service is not a babysitting program, but rather, a child care clinic, it provides an opportunity for adolescents to receive the support and reassurance in their new role as parents.

A final component of the program is community education. Approximately 145 presentations have been offered by the project's adolescent peer panel. Pregnant and parenting adolescents have been trained with peer counseling techniques and successfully have shared their personal experiences with over 3,000 youth and adults throughout the community.

Upon completion of the program, the client returns back to the home school with the necessary support services following. Follow-up services are provided at 6, 12, and 24 months after completion of the program.

Attached to the written testimony is a highlight of our evaluation that was conducted in 1981 under the title VI funds and in 1982 under the title XX funds.

The Adolescent Family Life Act demonstrates the commitment by Congress to provide comprehensive services by requiring all grantees to provide such core services as previously described, and in fact, our statistics show that 96 percent of our clients who receive these core services did not experience a second pregnancy within a year.

At this time, I would like to introduce to you Heather, and when she is through with her presentation, we would be happy to address any questions.

Senator DENTON. Thank you, Ms. Sanchez.

Go ahead, Heather.

HEATHER. As Peggy said, my name is Heather Davis, and I am 16 years old, and a mother. Justina, who is 16 months old, and I live with my parents in Florida.

During my pregnancy and 3 months after, I attended Project HELP. Project HELP did a lot for me in many different ways. I enjoyed being around other pregnant girls, and it gave me a feeling of belonging. I was uncomfortable at regular school, where I would get a lot of unwanted looks and remarks. When I say Project HELP did a lot for me, I know I speak for other girls, as well. Being young and pregnant is scary, and you need a lot of self-confidence. The workers at Project HELP understand and help us to cope better, as well as regain our self-confidence. We need more programs like Project HELP.

There are so many young pregnant teenagers and so few programs. Half the teenagers do not know about the programs we have today, and they drop out of school, which is not good for the mother or the baby.

We also need public schools which will allow the mothers to bring their babies. Mothers need a special bond with their babies, and when the mother is in school, it is hard to spend as much time together as needed.

I now go to night school, because I value my days with Justina. Justina is happier being with me in the daytime and my parents at night. When she is happy, I am happy, too.

I am not saying teenage pregnancy is all right or good. But it is happening more and more. And since it has not been stopped, we should at least do something to make sure these girls are getting an education and proper health care. With schools like Project

HELP, they would get their basic education, childbirth classes, birth control, breastfeeding, caring for their baby, and much, much more.

I learned a lot at Project HELP, and it has helped me to make many important decisions. They talked to us about all our options in keeping or giving up our babies. They spoke to me about adoption, but as you can see, I kept my baby. Do not get me wrong, I would not wish my worst enemy to be pregnant, but I made the mistake of trying sex at a young age, and I feel it is not the baby's fault, and she should not be punished. I would suggest adoption to anyone that did not have the support of their parents or did not feel they could handle it.

I know I made a mistake and I should have waited to be a mother, but now I have learned from my mistake, and I will raise my baby the best I can, with the help of my family and Project HELP.

[The prepared statements of Ms. Sanchez and Ms. Davis follow:]

My name is Peggy Sanchez. I am Director of the Y.W.C.A. of St. Petersburg's adolescent pregnancy program entitled Project H.E.L.P.

On behalf of our board, community agencies and pregnant and parenting adolescents, I thank you for inviting the Y.W.C.A. to testify for the reauthorization of the Adolescent Family Life Act of 1981. We strongly endorse that the Subcommittee give serious consideration to recommend the reauthorization of this act.

Project H.E.L.P. (Health, Education, Life Skills and Prevention for Pregnant Adolescents) is a community effort addressing the problems of pregnant and parenting adolescents and their families in Pinellas County, Florida.

Adolescent pregnancy programs throughout the country are confronted with the challenge of taking a devastating situation and creating an atmosphere which is conducive to the needs of the pregnant adolescent, the infant, and family members. However, limited grant awards will not allow this challenge to be attained when only a small portion of our youth and their families throughout the country are currently receiving services.

The reauthorization of the Adolescent Family Life Act is necessary in order to:

1. Continue and expand existing programs.
2. Allow for adequate evaluation and dissemination of the effectivness of existing demonstration programs.
3. Continue research in areas concerning adoption and adolescent sexuality.
4. And, most importantly, to allow for the continuation of services for our country's pregnant and parenting adolescents.

Even though substantial progress has been made since the original Adolescent Health Services and Pregnancy Prevention and Care Act of 1978 was authorized which stressed the comprehensive specialized approach to adolescents, it is now our opportunity to continue forward with more experience and an improved adolescent pregnancy legislation. With full funding of the Adolescent Family Life Act (AFL) and adequate time, we will be able to establish the background to deal with the problem of adolescent pregnancy in years to come.

While the future of adolescent parents does appear overwhelmingly bleak, it is essential to emphasize that these young parents are not to be labeled immoral or promiscuous, but rather as children who made a mistake and need support in making the best possible decision for themselves and their infants. They do not need to be hidden away from public view, to drop out of school or to become dependent on welfare. The opportunity to overcome these obstacles is confronting us now. By accepting this challenge we can provide opportunities which will alleviate the demoralizing results of a teenage pregnancy both to the individual and society. Let's not forget that regardless of our youth's physical ability to produce a child that these parents are yet children themselves. So my request before you today is to reauthorize the AFL, not with the intent of eliminating teenage pregnancy, but with a committment to alleviate the devastating consequences of a teenage pregnancy.

I wish to briefly discuss the organization and structure of the Project H.E.L.P. program to demonstrate that Adolescent Family Life grantees are in fact successful in providing core services, securing necessary community support and are carrying out the intent of the law.

Project H.E.L.P. has two sites separated by 30 miles. Combined sites provide services to 65 clients, ages 11-18, for an average length of involvement of 8 months. All services, except medical care, are provided on site at both centers.

Project H.E.L.P. is a cooperative effort administered by the St. Petersburg Y.W.C.A. It was funded and implemented under Title VI funds in 1981. Currently, the program is funded through Adolescent Family Life Act funds and multiple community agencies including Juvenile Welfare Board of Pinellas

County, City of St. Petersburg, Pinellas County, and School Board of Pinellas County.

The academic education component of the program offers an alternative school at both centers which is staffed by five certified teachers. Each teacher has no more than 15 students which enables individualized instruction. The adolescent can participate in this program and obtain all of the necessary credits for high school graduation. All records, grades and credits are transferable upon completion of the program.

Life skills education is provided daily through a combination of community agencies and Project staff. On site educational information is offered in such areas as child abuse prevention, nutrition, adoption, sexually transmitted diseases, responsible sexuality, parenting, consumer education and career planning.

Counseling services, provided through Family Service Centers, include individual, group and family counseling. The counselors monitor the client's progress, provide support and guidance and most importantly, act as an advocate for the adolescent as she receives services in the community. Clinical supervision is provided by a certified sex therapist.

Health services, including pregnancy testing, family planning, pre and postnatal and pediatric care is provided primarily through Pinellas County Health Department (PCHD). Coordinated efforts between Project H.E.L.P. and the Improved Pregnancy Outcome Program at PCHD have resulted in the establishment of a protocol which allows all high risk pregnant adolescents to participate in the maternity clinic at PCHD. In addition, PCHD has incorporated into their computer information necessary for the Project H.E.L.P. staff to effectively monitor the clients' progress. Pregnancy outcome information is readily accessible through this cooperative agreement.

Preparation for childbirth is taught weekly to clients, fathers of the babies and family members. This service provides individualized instruction and guidance with the realization that the average age of the Project's client is only 15 years. The development of an understanding of childbirth and labor and delivery is essential in order to decrease the youthful fears associated with childbirth.

Child care services are available at both centers for infants under 3 months of age. Since this service is not a babysitting program, but rather a child care clinic, it provides an opportunity for adolescents to receive support and reassurance in their new roles as parents. The parents are responsible for the feeding, changing, and necessary care of their infant. All young mothers participate in an infant learning class which teaches exercise and parenting techniques to stimulate the baby's growth.

A final component of the program is community education. Approximately 245 presentations have been offered by the Project's Adolescent Peer Panel. Pregnant and parenting adolescents have been trained with peer counseling techniques and successfully have shared their personal experiences with 3,271 youth and adults. Through these intervention efforts, youths as young as 9 and 10 years of age can begin to develop a responsible attitude toward adolescent sexuality.

Also under community education, support groups are available to teen fathers, adolescents who have completed the program, and family members.

Upon completion of the program, a client arranges for child care, returns to her home school/vocation training, and enrolls in a single parent counseling program. Follow-up referral services are provided at 6, 12, and 24 months after completion of the program.

Evaluations of the Project for 1981/82 and 1982/83 have been conducted by the University of South Florida. Attached is an overview of the evaluation.

The Adolescent Family Life Act demonstrates the committment by Congress to provide comprehensive services by requiring all grantees to provide such core services as previously described. And, in fact, our statistics show that 96% of our clients who received these core services did not experience a second pregnancy within a year. This is significantly lower than the national rate.

The Adolescent Family Life Act addresses the needs of the pregnant adolescent, her infant and family. We have only begun to suggest various approaches to resolve the problem. Quality evaluation and dissemination of the results can only occur after adequate time has been allowed to fully demonstrate the impact of existing programs.

On behalf of all pregnant and parenting adolescents, I urge you to support the reauthorization of this vitally important legislation.

Hello, my name is Heather Davis. I'm fifteen and a mother. Justina, who is 16 months old, and I live with my parents. During my pregnancy and three months after, I attended Project H.E.L.P.

Project H.E.L.P. did a lot for me in many different ways. I enjoyed being around other pregnant girls. It gave me a feeling of belonging and I was uncomfortable at regular school. I would get a lot of unwanted looks and remarks. When I say Project H.E.L.P. did a lot for me, I know I speak for other girls as well. Being young and pregnant is scary. And you need a lot of self-confidence. The workers at Project H.E.L.P. understand and help us to cope better as well as regain our self-confidence. We need more programs like Project H.E.L.P.

There are so many young pregnant teenagers and so few programs. Half the teenagers don't know about the programs we have and they drop out of school, which isn't good for the mother or the baby. We also need public schools that will allow the mothers to bring their babies. Mothers and babies need a special bond and when the mother is still in school, it's hard to spend as much time together as needed.

I now go to night school because I value my days with Justina. Justina's happier being with me during the day and with my parents at night. When she's happy, I'm happy, too. I'm not saying teenage pregnancy is all right or good. But it's happening more and more. And since it hasn't been stopped, we should at least do something to make sure these girls are getting an education and proper health care. And with schools like Project H.E.L.P., they would get their basic education, childbirth classes, birth control, breast feeding, caring for their baby and much more.

I learned a lot at Project H.E.L.P. and it's helped me to make many important decisions. They talked to us about all our options in keeping or giving up our babies. They spoke to me about adoption, but as you can see, I kept my baby. Don't get me wrong, I wouldn't wish my worst enemy to be pregnant. But I made the mistake of trying sex at a young age. And I feel it's not the baby's fault and she shouldn't be punished. I'd suggest adoption to anyone that didn't have the support of their parents or didn't feel they could handle it.

I know I made a mistake and I should have waited to be a mother. But now I've learned from my mistake, and will raise my child the best I can with the help of my family and Project H.E.L.P.

YOUNG WOMEN'S CHRISTIAN ASSOCIATION

PROJECT H.E.L.P.

In Fiscal Year 1982-1983, the YWCA - Project H.E.L.P. served 149 youths. Project H.E.L.P. services were provided at two locations, St. Petersburg and Clearwater. In 1981-1982, when 92 youths were served, services were only provided in St. Petersburg. A program expansion to Clearwater in January of 1983 resulted in a substantial increase in the number of youths served.

Of the 110 youths accepted by Project H.E.L.P. in 1982-1983, 31% were white and 69% were minority. Youths 10-14 years of age equaled 25% and youths 15-17 years equaled 75%. The majority of youths (77%) resided in families with an annual income of less than $10,000. 68% of the youths were from South Pinellas County and 32% were from North Pinellas County. 63% lived with only one parent.

457 referrals of clients were made to other community agencies. 401 or 88% of the referrals were followed-up on.

71% of the youths terminated completed their case plans. Other reasons for terminations included no longer eligible (12%) and lack of cooperation/motivation (10%). The percentage of youths who completed their case plans in 1982-1983 increased by 20% over the previous year.

Volunteers rendered 819 hours in 1982-1983, an increase of 49% over 1981-1982.

The average length of stay for youths in Project H.E.L.P. was 6 months. The average length of stay in 1981-1982 was 9 months.

An average waiting list of 9 youths was maintained during the year. An average of 3 youths were on the waiting list in 1981-1982.

The average caseload of counseling staff increased from 28 in 1981-1982 to 48 in 1982-1983.

Project H.E.L.P., in 1982-1983, met or exceeded twenty-one of its twenty-three measurable objectives and substantially met the two measurable objectives not attained. The program's overall achievement of its objectives was excellent.

A monitoring visit was conducted on January 12, 1983. The primary strengths of Project H.E.L.P. included:

1) Project H.E.L.P. was viewed as being of high value to pregnant adolescents and the community;

2) Project H.E.L.P.'s approach to providing services to pregnant adolescents was family oriented, and

3) Project H.E.L.P. has demonstrated the positive effects of its services in reducing repeat pregnancies (96% of youths who complete the program do not become pregnant within twelve months of leaving the program).

YOUNG WOMEN'S CHRISTIAN ASSOCIATION - PROJECT H.E.L.P.

	1980-1981		Title VI 1981-1982		Title XX 1982-1983	
	#	%	#	%	#	%
# Children Directly Served			92		149	
Children by Race/Sex:						
White Male			0	00%	0	00%
White Female			29	32%	34	31%
Minority Male			0	00%	0	00%
Minority Female			63	68%	76	69%
Children by Age:						
0-4			0	00%	0	00%
5-9			0	00%	0	00%
10-14			16	18%	27	25%
15-17			72	82%	83	75%
Children by Family Income:						
Under $10,000/yr.			60	69%	85	77%
$10,000-$20,000/yr.			20	23%	22	20%
Over $20,000/yr.			7	08%	3	03%
Children by Residence:						
South Pinellas Co.			90	100%	74	68%
North Pinellas Co.			0	00%	35	32%
Out-of-County			0	00%	0	00%
# Children From Single Parent Families			60	65%	69	63%
# Adults Directly Served			N/A		N/A	
# Families Directly Served			87		147	
# Referrals To Other Community Agencies			308		457	
# Referrals Which Have Been Followed-Up			239	77%	401	88%
Clients Terminated Due To:						
Completion of Case Plan			29	51%	52	71%
Other			28	49%	21	29%
Approximate # Volunteer Hours Rendered			548		819	
Average # Clients On Waiting List			3		9	
Average Months in Program			9 months		6 months	
Average Caseload of Counseling Staff			28		48	

Senator DENTON. Thank you, Heather. I certainly will not argue with your decision, either. I agree with everything you said. And you said, "I would suggest adoption to anyone who did not have the support of their parents or did not feel they could handle it. I know I made a mistake, and I should have waited to be a mother, but now I have learned from my mistake, and I will raise my child the best I can, with the help of my family and Project HELP."

Heather, how did you and your family work through this situation? How and when did they indicate that they would cooperate in helping you to raise your child and so on?

HEATHER. Well, for the first 7 months of my pregnancy, I was mentally not aware of it; I refused to accept it. And the doctors told me that because of my tension and not accepting that I was pregnant, that Justina felt my tension and hid herself. But when everybody found out that I was pregnant, it was accepted—everybody cried for the first couple of days, and my parents were disappointed, as all parents would be if their young children get pregnant.

My mom—my real mother—left when I was not even 2 years old, so I know how it feels to wonder why and things like that. So that is one of the great reasons why I did not give up my baby, because I do not feel it is right unless—like in Christy's case, she felt that she did not have the support that she needed to raise her baby, even though she does love her baby, which she always will, and she will have a feeling for that baby.

Me, I guess that the greatest part was that I had the support of my parents and my family, and going to Project HELP helped me cope with it more and realize that since my parents were going to help me, that I felt I would be able to raise that baby, and plus, my parents said they would help me in any way possible, and that if I could not raise the baby myself, that they would raise the baby for me.

My father mostly—because he raised five kids on his own when my mother left—said that he raised his own kids, and if he has to, he will raise his grandchildren, also. So he said that they would help me in any way possible.

And they asked me what would make me give up my baby, and I said the only reason I would give up my baby is if they said that I had to leave if I kept the baby. And the only reason I said that is because I have no other relatives in Florida, and I do not feel comfortable around my real mother, so really, they are the only family I have. So I feel that if it would have come between my family that, yes, I would have given her up.

Senator DENTON. So, part of the reasoning behind your decision was the memory of your mother, your real mother and you, parting when you were quite young?

HEATHER. Yes, knowing how it feels to wonder why she left and where she is. But I met my mother the first time when I was 14 years old, and we really do not get along, and I do not like her. When she found out I was pregnant, she offered to raise my baby, and it was mostly that she offered to raise my baby because she felt that by her raising my baby, it would take the place of her not raising me, my sister and three brothers.

Senator DENTON. Ms. Sanchez, I noted the statistic you mentioned and expressed your gratification about—I think it was 96 percent of the young women who complete the program do not become pregnant within 12 months of leaving the program, and you stated explicitly that that is a good bit better than the national statistics on similar situations.

How do you tend to account for that kind of a positive outcome? Would you estimate why this is so in your program?

Ms. SANCHEZ. Our program does offer family planning education. Obviously, we do not give the contraception at YWCA. However, we do encourage an awareness and a responsibility.

Overwhelmingly, though, all of the girls are told that there is a certain amount of responsibility that is involved that is not just a matter of contraception. Abstinence is stressed in the program; making the girls understand why they became sexually involved in the first place.

A large percentage of our girls are from single-parent homes, and oftentimes what these girls are telling us is that getting involved sexually was their vehicle to obtain some type of affection from, possibly, the missing male member in the family. I am not saying that occurs for all girls. But that is something that has been told to us by our clients.

So, through counseling, when we begin to address the reasons why girls are becoming sexually active, we feel confident that they also are taking more responsibility for their actions, which in effect, most likely, is a result of the 96 percent not repeating the pregnancy.

Senator DENTON. You mentioned the large proportion of adolescents who become sexually active early who come from broken homes. I feel lonely not only personally in having the only subcommittee in the Senate which has the word "family" in it, but I feel very lonely in terms of the task and the wherewithal one subcommittee has to address the issue of the broken family. I consider the broken family situation in the United States to be—I can only use the word you did—devastating, in its proportion in comparison to any other era in this Nation. I do not blame women, men, or any personal attributes for that. I do not know what the cause of it is. I am the child of a broken home myself; it occurred when I was in the seventh grade. We have had in this Family and Human Services Subcommittee, for your information, a series of hearings on the broken family and we addressed such issues as what can be done to improve the likelihood that young men and women will form attitudes and lifestyles which promote the probability that when they get married, they will have a stable marriage. I think that is an extremely important question which needs to be addressed to a degree by Government. There are a number of policies which the Government undertakes to impose upon the people of this country, or a number of policies that they do not choose to impose or enforce in the Nation.

We have looked into what it takes to eliminate as many of the causes as possible for families to break up once they are formed, and to give help to those after the families are broken up. It is a very sad task, but I must say it is a very necessary task. It is extremely important, as I mentioned earlier, in the context of promoting the general welfare and permitting the pursuit of happiness on the part of our people to the maximum degree possible.

What can you tell us about the practical effect of the restriction on the use of AFL funds for abortion activities, counseling and referral?

Ms. SANCHEZ. Our program is filling a gap in service. It provides services to those girls who have chosen to carry their pregnancies to term.

We, in 3 years of operation, have yet to have one girl come to us, asking for an abortion. I tend to feel that this can be explained primarily through what Heather said earlier, that there is a long denial period, and oftentimes—Heather, in fact, found out she was approximately 7 months along, which is too far along for an abortion.

However, we do feel that it is important that the committee receive more information on the legal option of abortion, to determine if the impact of this legislation has, in fact, prohibited any service delivery to a pregnant adolescent—again, emphasizing that our program does not particularly have any concerns in the past, and certainly in the present, we have not been confronted with that particular problem.

I do wonder if there are adolescents out there who may be coming to one of the adolescent pregnancy programs throughout the country and not be able to get to the appropriate counselor because of the restriction.

Senator DENTON. Well, it was deliberately placed as an alternative, and if the parents and the child request that referral, they get it.

Ms. SANCHEZ. If the parent signs, right.

Senator DENTON. Ms. Sanchez, can you tell me about the practical effect of the requirement for parental consent for the receipt of services under your program. Has that requirement apparently deterred adolescents from seeking services, and have parents of adolescents been willing to participate in the program, as a general rule?

Ms. SANCHEZ. Again, from the statistics that I attached to our testimony, you will see that the majority of the parents have participated in the program. Most of the parents are coming to us very grateful that there is a comprehensive program available in the area, and most of them not only come to the required parent-child conference, but they do follow up with the monthly meetings that are offered.

We do not feel in any way that this requirement has in any way prohibited services.

Senator DENTON. Well, thank you very much, Ms. Sanchez, and thank you, Heather, for your testimony this morning.

Ms. SANCHEZ. Thank you.

Senator DENTON. I will ask our next witness to come forward, Dr. Terrance Olson. Dr. Olson is a professor at Brigham Young University in Provo, UT. He is the director of BYU's Adolescent Family Life prevention project.

Senator Hatch was unable to be with us this morning, and I will include in the record his introduction of you, and I extend his apologies on his behalf. I know he would have liked to be here, Dr. Olson.

Welcome, and if you have a statement, we would be delighted to hear it at this time.

INTRODUCTION OF DR. TERRY OLSEN BY SENATOR HATCH

Senator Hatch. I am again honored to introduce Dr. Terrance Olsen, a professor of family sciences at Brigham Young University, Provo, UT and a grantee of the Adolescent Family Life Program. Dr. Olsen's experience in the field of marriage and family counseling dates back over 17 years. During that time he has amassed an impressive set of credentials and devoted much of his time to teaching and research. He has published and lectured extensively on topics pertaining to the family, parenting, adolescence, and education. Most recently, he has been implementing curriculum in the Utah school systems which teach students how to assess the moral and legal ramifications of behavior.

Dr. Olsen's work is critical to the issue of teenage sexuality. It represents a truly scientific breathrough in the resolution of these complex and important problems. I am proud that Dr. Olsen is a fellow Utah citizen and I and the members of this subcommittee welcome his comments and insights.

STATEMENT OF DR. TERRANCE D. OLSON, PROFESSOR, FAMILY SCIENCES, BRIGHAM YOUNG UNIVERSITY, PROVO, UT, AND DIRECTOR, ADOLESCENT FAMILY LIFE PREVENTION PROJECT

Dr. Olson. Senator Denton, I welcome the opportunity to address the subcommittee.

I will not read the written statement that I have already submitted, but will summarize it in anticipation of some questions.

I will also submit for the record an article, just recently accepted in a professional journal, which describes our project and gives more extensive views of what our project is about. It is entitled "Primary Prevention of Adolescent Pregnancy: Promoting Family Involvement Through a School Curriculum." It has been accepted for publication in the Journal of Primary Prevention, and I would submit that in addition to the written statement that I have given you.

Overall, the Adolescent Family Life Act of 1981 is a step forward in addressing the problems of teenage pregnancy because it places the family at the heart of prevention efforts. This is true whether we are talking about offering prevention services or care services. Teenage pregnancy is seen as a tragedy by professionals and parents alike. The Adolescent Family Life bill acknowledges the need for ambulances at the bottom of the hill, while at the same time, asking parents and society to consider constructing fences at the top of the cliff and maintaining them with some commitment.

The Adolescent Family Life Act honors the historical and legal tradition of limiting adolescents, as minors, from access to all the rights granted adult citizens and protecting them from bearing full adult responsibility for their behavior. This practice is a way of protecting teenagers while they develop maturity socially, emotionally, physically, and morally, to participate responsibly in a democracy.

Parental involvement is, again, central to this preparation, and the AFLA helps parents be the fence builders, along with other professionals, as you have noted.

I might say that once such legal parameters as acknowledging that minors are minors are eroded, it becomes increasingly difficult for parents, for social scientists, for legislators, to prevent problems associated with teenage sexuality. Often, our teenagers are taught that freedom of choice is an important gift that they have. But there is not much truth to be told about freedom of choice, and freedom of choice is no gift, if the choices do not matter. We cannot help our teenagers by lining up all the available choices to them, as if they were soap brands on the supermarket shelf, and as if it did not matter which one they chose.

So the AFLA takes a stand regarding the difference between wise behavior and unwise behavior, responsible behavior and irresponsible behavior. It offers prevention programs to teenagers that stand where they need to stand, acknowledging that some decisions are more destructive to the family and to the future of teenagers than are some other choices.

In our own project, we try to bring some criteria to bear on showing the difference between responsibility and irresponsibility. We talk about the impact of a decision on the family. We talk about decisions that would be in the best interests of the individuals involved. In listening to the previous testimony about promoting adoption, I thought of how we would discuss adoption with adolescents in our project. We ask them to make decisions by examining the best interests of the mother, the family of the mother, and the potential adoptive parents. We have to bring those criteria to bear in order to decide whether a decision is responsible or not.

The AFLA acknowledges that decisions by teenagers of ethical import are usually made best when parents are involved, and it restricts professionals from making decisions in the absence of parents. The example here would be the restriction on abortion counseling.

I am a clinical member of the American Association for Marital and Family Therapy. I know that as a private counselor, if I were seeing a teenager, a minor, and I counseled that minor toward abortion without parental involvement, I would not be an ethical professional in my conduct. So I see the AFLA's abortion restriction as simply trying to honor ethical professional practice of counselors.

The AFLA also invites professionals—and this is a very important part of the bill, Senator Denton—to pursue both obvious avenues of prevention of teenage pregnancy, which are to reduce teenage sexual activity and promote increased contraceptive use among sexually active teens. As pointed out by Kurt Back, a social psychologist at Duke University in a recently published article, when you review the prevention literature regarding adolescent pregnancy, the option of sexual abstinence has been neglected by professionals who create prevention programs. Back suggests that such neglect is a reflection of the personal values of professionals. This law encourages professionals to quit neglecting that option and asks professionals both to provide for contraception where appropriate, but more fundamentally, to work on the dimension of teenage sexual activity which promotes the problem in the first place.

In our own project, how are we implementing the mandate of the law? We teach a family centered curriculum in the public schools of selected districts in three States. We do that to reach as many teenagers from as many varying backgrounds as possible, and to show that the ideas that we are promoting are, in fact, universal. We try to link the school with the home in promoting a resolution of the problems associated with teenage pregnancy.

Our researcher at Utah State University, Brent Miller, with a pre/post control group design, has already identified at least three significant changes among students that take our curriculum, compared to control group students who do not. No. 1, they report less permissive attitudes toward premarital sexual relations than the control group. No. 2, they report higher family strengths, which is significant for us, because the research shows that if you put the family central to prevention efforts, and if you involve a teenager with the family, they are less likely to be involved with the problems associated with teenage sexual activity. That our students across States are reporting higher family strengths than the control group, gives us hope that we are on the right track. No. 3, we also have students reporting that they talk more with parents about sexual values and beliefs. By involving them with parents, we hope, based on previous research, that we can reduce the incidence of adolescent pregnancy among those teenagers.

We have other information that affirms that which has been found in previous research. Among other things, we know that sexual activity increases as a person's academic performance decreases—that is, students getting D's and E's report themselves as sexually active, compared to those who report C grades and above—the majority of those students report they are not sexually active.

Teenagers who report that they have plans for the future report very little sexual activity. And finally, if the age at which a female begins dating is postponed, the likelihood of her sexual activity is reduced even when she is 18 and 19 years old.

I did not pay as much attention to the lights, as I perhaps should have, so I am not sure that I have gone over time. Do you wish to ask questions, Senator?

Senator **Denton**. Yes, I do. You were answering some of the questions in your testimony, and that is why I did not stop you.

[The prepared statement of Dr. Olson follows:]

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Overall, the 1981 Adolescent Family Life Act (AFLA) is a step forward in attempts to alleviate the problems associated with teenage sexual involvement. Although the AFLA acknowledges the need for ambulances in the valley, it takes the bold step of actually suggesting that it would be worthwhile to build a fence on the edge of the cliff. And it does more. It enlists those most appropriately committed to protecting the young from cliff-hanging experiences -- parents.

The AFLA acknowledges the family as the most fundamental and prudent socializing agent available to teenagers, in contrast to the many current cultural philosophies of sexuality that promote unwise and self-destructive sexual behavior among minors. It attempts to restore an understanding of sexuality within the context of the family. The bill seeks to have families reassert their influence by becoming more involved and committed in the education of their children. It asks teenagers to examine more critically and responsibly the wisdom of having fences. In recognizing the power of family involvement in preventing teen health problems, the AFLA echoes similar approaches in the prevention of alcohol and drug abuse (Cohen, 1982; Coleman, 1978, Heller, Sher, & Benson, 1982).

The act also acknowledges the realities and practical consequences of children having children. In recognizing the power of family involvement in preventing teen health problems AFLA is working hand-in-hand with similar approaches in the Alcohol and the drug abuse prevention arena.

It is not just that sexual _activity_ among unmarried teenagers is premature, rather, it is usually the _individuals_ themselves who are "premature" or immature in their thinking about the physical, emotional, social and moral consequences of such behavior. The consequences of immaturity are sometimes further fostered by other immature acts that are often transmitted across generations.

The cognitive and moral reasoning skills of adolescents are still developing (Piaget, 1962, 1965, 1972; Kohlberg, 1966). This fact has been long acknowledged in our legal system, in that children, up to a specified age (18 is typical), are not allowed full access to the rights and responsibilities of citizens. As Hafen (1977) notes, "Children have been excluded purposely from full participation in democratic life." This exclusion is a way of preparing teenagers for the day when their moral development and reasoning capacity is sufficient to grant them full democratic rights. Hafen continues, "to abandon children [prematurely] to their rights, not only ignores the real needs of the children, but also creates within adults the false expectation that they, too, can be -- or should be -- "liberated" from arduous demands of a parental and community commitment to child rearing" (p. 475).

The bill, in advocating abstinence and other prudent approaches to the problem of teenage pregnancy attends to developmental, legal, familial and social realities. It takes a stand on high ground, where most of society wants (and where most parents want) to maintain a fence. But it is not just a high moral ground based upon one group's value preferences. Virtually all service groups and researchers working on the problem of adolescent sexual involvement agree that the consequences of such involvement -- not the least of which is single parenthood -- can be disastrous for the lives and futures of our young people. As a society, we agree that adolescents are not yet qualified for full participation in democratic affairs. Yet, when the legal system affirms a teenagers right to have access to contraceptives, and excludes parents from the right to know of such behavior, it is taking for granted that adolescents have a legal right to engage in sex which is independent of family constraints or of their own legal status as minors in their decision of whether to contracept. If there are practical, developmental, societal and familial reasons for adolescents not to be granted the full rights and responsibilities of adulthood, then why do the courts erase that historical, legal distinction in the case of sexual behavior? How is it possible that an adolescent who has not yet reached full capacity in thought, in emotional maturity, social interaction, moral reasoning, etc., possesses the sophisticated capacity to make responsible (adult?) decisions about intercourse and contraception?

When this erosion of legal commitment to the protection of minors is linked to the many societal invitations to teenagers for sexual involvement, it poses major obstacles to the parent, social scientist, or legislator who wishes to undertake the task of preventing problems so destructive to an adolescent's future.

If the issue is prevention of the problems associated with sexual activity, it is curious, even for pragmatists, to attack the symptoms of the problem (i.e. teenage pregnancy, venereal disease, etc.), and at the same time they seem to accept the behavior which produces the symptom (sexual intercourse among unmarried minors) as legitimate. Back (1983) has documented that the approach of a majority of social scientists to solving the problem of teenage pregnancy is limited to one model focusing exclusively on contraception to the exclusion of a scientific alternative. Teenage pregnancy is a problem due both to increased sexual activity and insufficient contraception. Yet, after examining the prevention literature, Back comments, "we are struck by the preponderance of research and application on the second factor -- the use of contraceptives, to the virtual exclusion of the first, the increase of teenage, nonmarital intercourse" (p. 2). As Chilman (1980) also observed that:

> The dictim that some would give to people, including adolescents, "Have any sex experience you want, but don't get pregnant or become infected with venereal disease," is essentially dehumanizing. It implies that we don't care what happens to the psychological or social person as long as his or her physical problems do not burden society (p. 4).

Such scientific myopia is not due solely to practical limitations in the culture; but reflects the values that researchers themselves adhere to in choosing their avenues of intervention. Back further states:

> These values determine a perceptual scheme which can organize the views of the researchers: they define what is unchangeable and what is changeable and subject to policy. The wholehearted acceptance of adolescent freedom, the recognition of adolescent sexual needs and the general philosophy of self-realization have set definite parameters of the work on adolescent pregnancy . . . . The result has been that improved birth control education -- perhaps with some warning about early intercourse thrown in -- and increased availability of services is the only viable policy for reducing teenage fertility . . . . Taking as an example, the Alan Guttmacher Institute Report (1976), we see that practically all the data refer to "sexually active teenagers," not to the conditions in which they become sexually active. We also find little research interest in the conditions of reduced intercourse, as a glance through recent studies (Zelnick *et al*., 1981, Furstenberg *et al*., 1981) of teenage pregnancy reveals (1983, p. 4).

Suffice it to say, to draw the prevention line at pregnancy, without being willing to honor legal, social and familial constraints regarding intercourse, is a value laden, ideological decision, not a scientific one. Furthermore, it is a value preference that, to date, has not reduced the negative consequences that affect the lives of millions of our young people.

Fortunately, the Adolescent Family Life Act does not abandon those who have already become sexually involved (it does provide ambulances in the valley), but it also takes seriously the neglected option of avoiding premuture sexual involvement among teens. The legislation invites family life educators to view the problem with both eyes, to assist parents in the maintenance of fences on the cliff, and thus addresses the problems with a greater depth of vision.

I do not wish to imply that the OAPP funding under this law is a magic formula for success in curbing teenage pregnancy, but it does not artificially restrict professionals to a focus on only one factor, contraceptive use, that contributes to the incidence of adolescent pregnancy. It also invites professionals to marshall parental influence in attempts to solve the problem. This is a powerful contribution of the AFLA, since previous research (Chilman, 1980; Miller, 1981) indicates that, in comparison with sexually active peers, both male and female adolescents who had not experienced sexual relations:

- had more open communicaiton with parents, especially with fathers
- felt that their parents' discipline was more consistent
- were more likely to consider themselves to be "A" students
- were more likely to think it was very important to their parents for them to get good grades in school
- were more likely to have plans to go on to college
- considered themselves to be more religious
- felt more responsible to parents, society, and God for their personal behavior
- were more likely to learn about intercourse from their parents
- were more likely to feel that sex educaiton from parents was adequate

- were more likely to think petting and intercourse before marriage is wrong
- were less likely to have close friends who had petted and had coitus

Our particular prevention project funded by OAPP has produced preliminary data which affirm that prevention programs which reach out to parents can succeed both in promoting family involvement, and in changing attitudes. Our project consists of the delivery of a family-centered public school curriculum (Wallace & Olson, 1982) in selected school districts in three states. Data already collected in two of the states by Brent Miller of Utah State University, shows that students who receive the curriculum (the experimental group), as compared to the control group, differ in the following ways:

(a) they have less permissive attitudes toward premarital sex

(b) they report that parents talk to them more now about sexual values and beliefs

(c) they report higher family strengths (trust, loyalty, respect, etc.)

Whether the increased family involvement and initial change in attitudes will continue will not be clear until the longitudinal study is completed. But the curriculum already demonstrates that it is possible to teach students a comprehensive view of human behavior which shows the moral meanings of human experience and offers them criteria by which to assess decisions and behaviors as related to themselves, their families and society. It attempts to teach minors how to prepare for the time when they assume full legal and moral responsibility for their decisions and behavior.

Our project has taught us that the ideas we are teaching, which are unconventional when compared to standard family life curricula, are understandable to adolescents. In some cases, teachers have reported to us that even their most difficult students come alive with the substance of our work. Yet, we face limitations. Our approach would be more powerful if it were central to a given high school curriculum and if its basic ideas were available in required courses. It may be that ideas such as ours should be introduced earlier than high school. But, our program does require quality teachers committed to learning, to fostering logical thinking, and to promoting responsible family behavior in students.

However, the approach we have been taking is a promising alternative that teaches about family values and individual responsibility. It places responsibility on the individual and shows how irresponsible behavior is a moral and ethical issue, always accompanied by self-justifying attitudes (Warner & Olson, 1981). By abandoning such self-deceptions, teenagers can free themselves from the very circumstances and behaviors which produce and promulgate the negative consequences associated with premature sexual involvement.

One limitation of the bill is its failure to allocate sufficient funding for adequate data collection procedures which help document behavior or attitude change in adolescents I understand that the money is to go for actual delivery of programs and not for extensive, non-intervention research, however, primary prevention programs do not have a captive audiences already defined by a specific symptom. Therefore, ways must be found to obtain data from a population only hypothetically at risk for pregnancy. There are creative ways of obtaining such data, but it is a time-consuming longitudinal process. The 5 percent budget limitation on research associated with prevention projects is inadequate for such responsible data collection.

Finally, Senator Denton, I know you have taken considerable criticism, as chairman of this subcommittee and as author of the Adolescent Family Life Bill, for considering alternative solution to the problems of teenage sexual involvement and teenage pregnancy You have encouraged us to look at neglected prevention options You have dared to consider that prevention of unwise sexual involvement can be a most effective approach I thank you for your common sense and courage I believe the evidence is accumulating that will prove you have been on the right track all along

References

Alan Guttmacher Institute. (1976). *11 Million Teenagers: What can be done about the epidemic of adolescent pregnancies in the U.S.* New York.

Back, K.W. (1983). Teenage pregnancy: Science and ideology in applied social psychology. In R. F. Kidd and M. J. Saks (Eds.). *Advances in applied social psychology*, Hillsdale, NJ: Erlbaum, *2*, 1-17.

Chilman, C. (Ed.) (1980). *Adolescent pregnancy and childbearing: Findings from research*. Washington, D.C.: Department of Health and Human Services.

Cohen, S.J. (1982). Helping parents to become the "potent force" in combating and preventing the drug problem. *Journal of Drug Education*, *12*, No. 4, 341-344.

Coleman, S.B. (1978). Sib group therapy: A prevention program for siblings from drug-addicted families. *Internation Journal of the Addictions*, *13*, No. 1, 115-127.

Furstenberg, F.F., Lincoln, R., & Menken, J. (1981). *Teenage Sexuality, Pregnancy and Childbearing*, Philadelphia: University of Pennsylvania Press.

Hafen, B.C. (1977). Puberty, privacy and protection: The risks of children's "rights". *American Bar Association Journal*, *63*, 1383-1388.

Heller, K., Sher, K., & Benson, C. (1982). Problems associated with risk overprediction in the studies of offspring of alcoholics: Implications for prevention. *Clinical Psychology Review*, *2*, No. 2, 183-200.

Kohlberg, L.A. (1966). A cognitive-developmental analysis of children's sex-role concepts and attitudes. In E. Maccoby (Ed.), *The development of sex differences*. Stanford, CA: Stanford University Press. 82-172.

Miller, B.C., Jenson, G., Kreuger, M., Peterson, T., & Weiner, A. (1981). *Teenage pregnancy: A comparison of certain characteristics among Utah youth*. Salt Lake City, Utah: Utah State Board of Education.

Piaget, J. (1962). *Judgment and reasoning in the child*. (Warden trans.) London: Routledge and Paul. (Orig. published in 1928).

Piaget, J. (1965). *The moral judgment of the child*. (M. Gabian trans.) New York: The Free Press.

Piaget, J. (1972). Intellectual evolution from adolescent to adulthood. *Human Development*, *15*, 1-12.

Wallace, C. & Olson, T.D. (1982). *Family life education: An alternative national curriculum*. (An unpublished manuscript)

Warner, C.T. & Olson, T.D. (1981, October). Another view of family conflict and family wholeness. *Family Relations*, *26*, (3), 493-503.

Zelnik, M., J.F. Kantner, & Ford, K. 1981. *Sex and Pregnancy in adolescence*. Beverly Hills: Sage.

Senator DENTON. I appreciate some of your comments which dealt with my own motives and so on.

Dr. OLSON. I might say that my project is a prevention only project, and that means that the audience is a little bit different than the audience for care services people. The people coming to our classes, of course, do not have any symptom to define them, and therefore, the kind of material we deliver makes the assumption that while they are at risk for pregnancy, it does not take for granted that they will become sexually involved.

Senator DENTON. You make the interesting point that, "Primary prevention programs do not have a captive audience already defined by a specific symptom," and therefore, that research efforts are doubly difficult. Taxpayers as well as Senators like to see and understand results of dollars spent on Federal programs that promote the general welfare, so in layman's terms, would you care to explain how we might find creative ways of obtaining more and better research data on prevention programs?

Dr. OLSON. That refers to the fact that ultimately, I and other grantees in the prevention area have got to show the way in which our project actually reduced the incidence of adolescent pregnancy. There are no records easily available in school districts or in clinics that can document whether or not somebody in a public school program like ours has received services for pregnancy. That means that we must get the data from the source, which is the teenager or the parents of that teenager. There is something ethically challenging about going to a group of 14-year-olds or 15-year-olds, who you do not know regarding their sexual activity, and beginning to ask them questions like, "Are you pregnant?" It is different to ask the parents that question, and even the research question I just noted that might be asked of teenagers must be done with parental consent.

So already, our data collection group is restricted from that which a care services project has. A care services project, in the moment that they are treating a pregnant teenager I assume, obtains permission for research data collection with that population. But with a prevention group, especially a control group of students in the public arena, who have never seen or heard of us—all they are doing is filling out questionnaires—we must be very cautious not to violate sensitivities of parents, and not, in our attempts to promote family involvement to solve this problem, actually create problems by the nature of the questions we ask.

So, one of the creative ways we are gathering data is to do mailings to both teenagers and parents, but with their consent, and then to do the extensive followup necessary to get the percentage response that allows us to have reliable data. If we only get 30 percent response in a mailed questionnaire, we can hardly draw the kinds of conclusions we would like to. Most of our early data collection is done in the classroom, and therefore, we have 100 percent response in our baseline and our beginning collection is excellent. But to follow students from 3 to 5 years to document their future sexual behavior and/or pregnancy rates is an interesting challenge. We are still trying to undertake that.

I might say, however, that we have organized a project which is designed to work itself out of a job. If what we are doing is worthwhile, it will be able to stand on its own and be run by the school districts that we are in, after the funding period is over. It is a true demonstration project, in that as soon as we discover enough about its success or failure, it will either be dropped or will be adoptable by those districts without additional funding.

Senator DENTON. I will ask this question of you and the other witnesses, and if I neglect to do so, I will make sure that we send it in writing. But as someone who has developed and had experience with a curriculum for use in public schools, do you have any sense of whether there is greater acceptance of curricula by parents in the community when the curriculum contains values that might be thought to be more traditional, or described as more traditional?

Dr. OLSON. Yes, definitely. In 2 years, we have had one complaint from a parent regarding our work. It was the complaint of a parent in a control group who wondered why we were asking the research questions we were asking.

I have sent him the material, and he has been surprised that what we are presenting is family-centered and supportive of the home, in contrast to curricula that he has opposed in the past.

So we have a sense that in our parent meetings, when we tell them what we are doing and introduce our concepts, they say, "This is the kind of thing that I could support. This, I can get behind. This, I can be involved in."

That was our intent from the beginning. Our goal was to promote parental understanding and involvement, and to help teachers in the public schools represent parents for the adolescents they teach, rather than stand between parents and the adolescents that they teach.

Senator DENTON. Yes, that is our feeling, that we question the right of Government to deny the right of parents access to their own children at a critical age, an age which is not only critical with respect to the moment, but to the rest of the lives of the children and, perhaps, of their children that might be born as a result of early sexual activity.

Senator Hatch requested that I ask you the following questions.

From your experience in the schools, and as an AFLA grantee, what does your data show as to the social problems which have accelerated adolescent sexuality. Do you have any new data to share with us today?

Dr. OLSON. Some of the initial correlations that we are analyzing now show that the incidence of sexual activity is less than the popular press would suggest, at least among those 14 and above, and it affirms that all teenagers who are not yet fully mature may need, in order to make decisions not destructive of their future, to be formally encouraged with defensible academic teachings, that their future may be benefited better by abstinence than by getting involved sexually.

The material on grade-point average, I do not believe is new. I believe that has been documented in previous studies by Chilman and Miller. But we have found also that students who report grade C and above are not involved, sexually active——

Senator DENTON. Excuse me, Dr. Olson. We may not have those statistics you referred to in a general way. Would you send us the statistics that deal with the relationship between school grades and likelihood of sexual activity?

Dr. Olson. Yes, we would be happy to do that.

[The following was received for the record:]

Excerpts From . . .

TEENAGE PREGNANCY

A Comparison of Certain Characteristics among Utah Youth

Utah State
Office of
Education

August
1981

TEENAGE PREGNANCY

A Comparison of Certain Characteristics Among Utah Youth

A Research Report Prepared for

The Utah State Office of Education

G. Morris Rowley, Project Monitor

(pursuant to USOE contract No. 81-0385)

by

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Home Economics and Consumer Education, Utah State University

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F. School Background and Achievement

The school-related comparisons of adolescents who had and had not experienced intercourse are displayed in Table 11. With the exception of participation in extracurricular activities and vocational education classes, all of the items included in this section of the interview were effective discriminators between those who had and had not experienced intercourse. This was true for both males and females in a theoretically consistent way.

Table 11

SCHOOL-RELATED CHARACTERISTICS OF ADOLESCENTS
WHO HAVE AND HAVE NOT HAD COITAL EXPERIENCE

Interview Response	Female		Male	
	Had Coitus (n=76)	Not Had Coitus (n=86)	Had Coitus (n=22)	Not Had Coitus (n=68)
Percent Seniors	62.7%	47.7%	68.2%	47.1%
In same grade as age mates	72.4%	86.0%	63.6%	85.0%
Consider self "A" student	21.1%	38.4%	4.5%	30.9%
Grades reflect abilities very well	17.1%	26.7%	4.5%	23.5%
Very important to parents to get good grades	52.0%	64.0%	54.5%	64.2%
Lots of extracurricular activity	28.0%	47.7%	50.0%	48.5%
Schools met my personal needs very well	18.2%	37.2%	17.1%	25.0%
Now taking Vocational Education course(s)	60.5%	46.5%	27.3%	32.0%
Plan to go to college	32.4%	65.5%	33.3%	55.2%

Roughly two-thirds of those who were sexually experienced were seniors, as compared to about half of those who were abstinent. Eighty-five percent of those who had not had intercourse were in the same grade as their age mates, compared to only 72 and 63 percent of the sexually active females and males respectively. This was not particularly surprising for the girls because some of them had become mothers and were more likely to have fallen behind in school. However, the grade-level discrepancy was even more pronounced for the sexually experienced boys, only 3 of whom were married. Admittedly the numbers are small, but 6 of the 22 (27%) sexually experienced males were behind their grade level in school; 20 percent of the girls who had experienced intercourse were behind their grade level. The item asking students to appraise their academic standard reinforces the grade level finding above. The proportion of sexually active females who considered themselves "A" students (21%) was about half of the abstinent girls (38%), and only one sexually active boy out of 22 considered himself an "A" student as compared to about one out of three among the sexually abstinent peers.

In a similarly consistent way, both sexually active females and males were less likely to report that their grades reflected their abilities well, and that it was very important to their parents that they get good grades in school. Consistently with expectations for both sexes, sexually active adolescents were also less likely to say that schools had met their personal needs well and that they planned to go on to college. The lower percentage of sexually experienced females planning to go to college might be considered an artifact of there being mothers in this group. However, an almost identical pattern was present among the male students, few of whom were married. The sex differences that appear in the lower involvement of girls in extracurricular activities and the greater percentage taking vocational education courses are, however, likely to be attributable to motherhood.

In summary, more consistent across sex than any area or domain yet analyzed, the school background and achievement of adolescents clearly differentiates between those who have and have not experienced sexual intercourse. It is evident that outstanding students, male or female, are much less likely to become involved in early sexual intercourse or pregnancy.

Senator **Denton**. Excuse me. Please continue.

Dr. **Olson**. We are particularly interested in the response of adolescents to our teachings about the meaning of their decisions to the family across generations—that is, more of the teenagers report that they understand the family implications of sex. They report, in responding to vignettes that we write for them to analyze, a kind of moral sensibility that some research indicates adolescents do not possess.

We have found that adolescents have an ability to respond intuitively to their felt understanding of what is responsible or not, whether they are able to formally state it as an adult would or not.

Senator **Denton**. From your personal experience, could you comment on the grant process and the administration of the Adolescent Family Life Demonstration Program under the Deputy Assistant Secretary for Population Affairs?

Dr. **Olson**. Well, we were funded in October of 1982 and renewed in October of 1983. We submit reports semiannually and annually, and the Office of Adolescent Pregnancy Programs has been helpful in watching us refine our program. When we have noted problems with it, they have said, "Have you thought of solutions?" And we have worked with them to iron out practical delivery problems of our program.

The review of grants is done by professional peer review, I assume, and I am not privy to the actual decisionmaking process, but have been appreciative of the support both practically, technically and academically since we have received the grant.

Senator **Denton**. Well, thank you very much, Dr. Olson.

We appreciate very much your testimony today, sir.

Dr. **Olson**. Thank you.

Senator **Denton**. Our next witness will be Dr. Marion Howard, and I will ask her to come forward.

Dr. Howard is an associate professor in the Department of Obstetrics and Gynecology at Emory University in Atlanta, GA, and she directs an Adolescent Family Life Prevention Program.

We welcome you today, Dr. Howard, and ask you for any statement which you care to give, remembering that we are trying to stay within 5 minutes.

STATEMENT OF MARION HOWARD, PH.D., ASSOCIATE PROFESSOR, DEPARTMENT OF GYNECOLOGY AND OBSTETRICS, EMORY UNIVERSITY SCHOOL OF MEDICINE, ATLANTA, GA

Dr. **Howard**. Thank you, Senator.

Prevention of teenage pregnancy is a complex issue with no simplistic solution. We must ask ourselves hard questions and come up with difficult answers.

Indeed, teenage pregnancy may be a consequence of some other problem that we as a society are facing. What is that problem?

Is the problem the changes in values and beliefs that include marriage; divorce; reevaluation of women's roles, rights and responsibilities; family life, sexual behavior?

Is the problem the economic situation in our Nation and our cities?

What happens to life expectations of young people when there are no jobs for them; when, even if they graduate from high school, their likelihood of finding meaningful employment leading to well-paid careers is absent?

Is it the social climate of today's society which seems to deeply involved in sexuality? Advertisements, books, provocative magazines, films, music and television programs have an enormous amount of sexual content.

Is it ignorance, lack of awareness? Most studies seem to show that knowledge alone does not change behavior.

I work in a hospital where doctors and nurses smoke. Can we assume just because we give young people reproductive facts that that is sufficient to help them control their reproductive behavior?

Is the problem how we view parenthood or are acting as parents?

Is the problem that we have no role for youth in a technological society in which unskilled, untrained labor is not needed?

Is the problem that biological maturity has outstripped psychosocial maturity? One hundred years ago, young people became fertile around the age of 17, and this nearly coincided with the age of marriage. Currently, the average age of fertility is 12½.

Is it the fact that many of our youth have low self-esteem and needs that they feel can be solved by sexual behavior?

Is it the need for more and better services for youth, lower student/teacher ratios, more recreation, more family planning or sex education?

Until such time as the answers to these and other questions become clear, we need to try a variety of approaches to try to reduce the numbers of young people who become pregnant prematurely.

The role of stimulating and supporting a variety of innovative efforts to reduce teenage pregnancy while maintaining traditional efforts that have been helpful in this direction is best filled by the Federal Government. The legislation under study for renewal at this hearing, although designed primarily to help those who become pregnant at a young age, can play an important role in helping seek the knowledge that will enable us to do a better job of preventing such pregnancies.

I direct a family planning program in which we see 1,200 sexually involved young people age 17 and younger each year. This is the Emory/Grady Teen Services Program at Grady Memorial Hospital. Over two-thirds of the young people we serve have already had a baby. The remainder have never been pregnant. A recent research study shows that we are very successful in helping these young people prevent pregnancies. A followup study of our young patients showed that as much as five years later, close to 80 percent were pregnancy-free. This is true for both those who had had one child, as well as those who had never become pregnant. Therefore, sound family planning services play a vital role in reducing teenage pregnancy.

However, no method of family planning is 100-percent effective. Further, there are other problems negative to the health and welfare of young people that can result from premature sexual involvement. Hence, other approaches are needed.

Studies of those factors which influence young people's values and attitudes and behavior show that in 1960, parents, peers, and teachers were the primary influences on youth. Today, 1980, peers have replaced parents as the No. 1 source. Parents are number two. The media has replaced teachers as the third most important source.

Hence, helping youth cope with influences of peers and the media is an important key to reducing teenage pregnancy.

In Atlanta, GA, a series entitled, "Postponing Sexual Involvement," has been developed to help young people resist social and peer pressures to become sexually involved before they are ready for such involvement. The series is designed to provide young people with tools to help them bridge the gap between their physical development and their cognitive ability to handle the implications of such development.

The aim of this series is to present information regarding the general nature of relationships, sources of societal pressure influencing sexual behaviors and assertive responses which teens can use in peer pressure situations. This knowledge and these skills should help young teens deal with involvement until a time when they are better able to make decisions which have a long range impact on their lives.

The series is a four part series—each of the four sessions is 1½ hours in length. The first session on social pressure contains information and exercises relating to social pressure. The sessions promotes understanding of why some teens might become sexually involved to meet various needs. It includes information on how such needs could be better met in other ways.

Session two on peer pressure presents information and exercises relating to peer pressures. This session promotes understanding of peer pressures in group situations and on a one-to-one basis.

The third session presents information and exercises related to problem solving. This session promotes understanding of ways to look at limiting expressions of physical affection. It provides guidance in handling difficult social situations. The final session is a reinforcement session on using new skills. It includes a review of skill and provides opportunities for additional skills practice. This session is held several months after the first three sessions.

Through funds granted by the Office of Adolescent Pregnancy Programs 950 volunteers are being trained to present the series to youth age 13–15, with the goal of reaching close to 60,000 youths in Georgia by the end of 1986. Special support activities will help create support for less-pressured sexual decisionmaking and encourage young people to postpone sexual involvement.

A parental involvement component of postponing sexual involvement educational series allows parents to receive a shortened version of the series so that they can reinforce their young teenager's learning experiences.

Field test results of the series showed young people found the series to either be extremely helpful or very helpful. Evaluation of the statewide dissemination effort will show whether or not building a broad climate of community support along with providing trained volunteers to reach teenagers with specific skill-building techniques will achieve the ultimate goal of reducing teenage pregnancy.

This series does not replace sex education. Sex education is also needed because no one operates intelligently in a vacuum. However, we feel this series provides a realistic addition to available teenage pregnancy prevention efforts. Over 80 percent of the young people we surveyed in our family planning clinic for sexually active teens wanted more information on how to say "No" without hurting the other person's feelings.

We are indeed pleased that the Federal Government is willing to support a variety of efforts in the area of teenage pregnancy prevention, including such approaches as helping young people resist social and peer pressures so that they can indeed postpone sexual involvement, which we feel is very inappropriate for young adolescents.

Senator DENTON. There are some articles in the St. Louis Post Dispatch referring to you and your program. One dated March 26, 1984. There is an article in the Atlanta Constitution, dated June 27, 1983. There is some material here from your brochures.

If you have no objection, I would like to include these in the record of our hearing.

Dr. HOWARD. I have no objection.

Senator DENTON. Without objection, for the record, from Senators, they will be so included.

[The following was received for the record:]

POSTPONING SEXUAL INVOLVEMENT
A PREVENTION PROGRAM FOR ADOLESCENTS 13-15 YEARS OF AGE

by Marion Howard, Ph.D.
Associate Professor
Department of Gynecology and Obstetrics
Emory University School of Medicine
Atlanta, Georgia

Prevention of teenage pregnancy is a complex issue with no simplistic solution. We must ask ourselves hard questions and come up with difficult answers.

Indeed teenage pregnancy may be a consequence of some other problem that we as a society are facing. What could the problem be?

Is the problem the changes in values and beliefs that include: Marriage; divorce; re-evaluation of women's roles, rights, and responsibilities; family life, sexual behavior?

Is the problem the economic situation in our nation and our city? What happens to life expectations of young people when there are no jobs for them, when even if they graduate from high school, the liklihood of their finding meaningful employment leading to well-paid careers is absent?

Is it the social climate of today's society which seems so deeply involved in sexuality? Advertisements, books. provocative magazines, films, music and television programs have an enormous amount of sexual content.

Is it ignorance, lack of awareness? Most studies seem to show that knowledge alone does not change behavior. I work in a hospital where doctors and nurses smoke. Can we assume just because we give young people reproductive facts, that that is sufficient to help them control their reproductive behavior?

Is the problem how we view parenthood or are acting as parents?

Is the problem that we have no role for youth in a technological society in which unskilled untrained labor is not needed?

Is the problem that biological maturity has outstripped psycho/social maturity? A hundred years ago, young people became fertile around the age of 17 and this nearly coincided with the age of marriage. Currently, the average age of fertility is 12.5.

Is it the fact that many of our youth have low self-esteem and needs that they feel can be solved by sexual behavior?

Is it the need for more and better services for youth, lower student teacher ratios, more recreation, more family planning and/or sex education?

Until such time as the answers to these and other questions become clear, we need to try a variety of approaches to try to reduce the numbers of young people who become pregnant prematurely. The role of stimulating and supporting a variety of innovative efforts to reduce teenage pregnancy while maintaining traditional efforts that have been helpful in this direction is best filled by the Federal Government. The legislation under study for renewal at this hearing although designed primarily to help those who become pregnant at a young age can play an important role in helping seek the knowledge that will enable us to do a better job of preventing such pregnancies.

I direct a family planning program in which we see 1,200 sexually involved young people age 17 and younger each year. This is the Emory/Grady Teen Services Program at Grady Memorial Hospital. Over two-thirds of the young people we serve have already had a baby. The remainder have never been pregnant. A recent research study shows that we are very successful in helping these young people prevent pregnancy. A follow-up study of our young patients showed that as much as five years later close to 80% were pregnancy free. This was true for both those who had had one child as well as those who had never become pregnant. Therefore sound family planning services play a vital role in reducing teenage pregnancy.

However, no method of family planning is 100% effective. Further there are other problems negative to the health and welfare of young people that can result from premature sexual involvement. Hence other approaches are needed.

Studies of those factors which influence young people's values,attitudes and behaviors show that in 1960 parents, peers and teachers were the primary inlfuences on youth. Today (1980) peers have replaced parents as the number one source. Parents are number two. The media has replaced teachers as the third most importance source.

Hence helping youth cope with influences of peers and the media is an important key to reducing teenage pregnancy.

In Atlanta Georgia a series entitled Postponing Sexual Involvement has been developed to help young people resist pressures to become sexually involved before they are ready for such involvement. The series is designed to provide young people with tools to help them bridge the gap between their physical development and their cognitive ability to handle the implications of such development.

The aim of this series is to present information regarding the general nature of relationships, sources of societal pressure influencing sexual behaviors and assertive responses which teens can use in peer pressure situations. This knowledge and these skills should help young teens deal with problem situations so that they can postpone sexual involvement until a time when they are better able to make decisions which have a long range impact on their lives.

The series is a four part series - each of the four sessions is one and a half hours in length. The first session on social pressure contains information and exercises relating to social pressure. The session promotes understanding of why some teens might become sexually involved to meet various needs. It includes information on how such needs could be better met in other ways.

Session two on peer pressure presents information and exercises relating to peer pressures. This session promotes understanidng of peer pressures in group situations and on a one-to-one basis.

The third session presents information and exercises related to problem solving. This session promotes understanding of ways to look at limiting expressions of physical affection. It provides guidance in handling difficult social situations.

The final session is a reinforcement session on using new skills. It includes a review of skills and provides opportunities for additional skills practice. This session is held several months after the first three sessions.

Through funds granted by the Office of Adolescent Pregnancy Programs, 950 volunteers are being trained to present the series to youth age 13-15 with the goal of reaching close to 60,000 youth in Georgia by the end of 1986. Special support activities will help create support for less-pressured sexual decision-making and encourage young people to postpone sexual involvement.

A parental involvement component of the Postponing Sexual Involvement Educational Series allows parents to receive a shorthened version of the series so that they can reinforce their young teenager's learning experiences.

Field test results of the series showed young people found the series to either be extremely helpful or very helpful. Evaluation of the state-wide dissemination effort will show whether or not building a broad climate of commuinity support along with providing trained volunteers to reach teenagers with specific skill-building techniques aimed at helping them say 'no' to sexual involvement will achieve the ultimate goal of reducing teenage pregnancy.

This series does not replace sex education. Sex education is also needed because noone operates inteligently in a vaccuum. However, we feel this series provides a realistic addition to available teenage pregnancy prevention efforts. Indeed results of a random sample survey conducted on the young people in our family planning clinic prior to our development of the Postponing Sexual Involvement Series showed that one of the main pieces of information such young people wanted was 'how to say no without hurting the other person's feelings.' Over 80% of the young people indicated this need and it was the most frequently checked item of information on the long list of information items we presented them.

We are indeed pleased the Federal Government is willing to support a variety of efforts in the area of teenage pregnancy prevention including such approaches as Postponing Sexual Involvement.

April 1984

St. Louis Post-Dispatch (Mo.); 3-26-84

Teen Pregnancy Prevention Plan Winning Notice Around Nation

By Ellen Futterman
Of the Post-Dispatch Staff

The effectiveness of a teen-age pregnancy prevention program in the St. Louis public schools has prompted the Association of Junior Leagues Inc. to start similar programs in cities nationwide.

About 100 representives of the league met for a two-day conference, which began Sunday, at the downtown Marriott Pavilion Hotel. They came to listen to speakers describe the widespread problem of teen-age pregnancy and learn about Teen Outreach. The program has succeeded in reducing the number of teen-age pregancies in St. Louis and helped adolescents finish high school here.

Under the program, about 125 high school and middle school students in groups of 25 meet twice a week at five district schools. Discussion topics usually center on such issues as human sexuality, drug use and employment opportunities.

The program is now operating at Vashon and Central high schools; at the Siegel Community School, near McKinley High School, and at Columbia and Fanning middle schools. Participants at the high school level can get school credit.

Participants also must perform at least three hours each week of volunteer work in nursing homes, hospitals and day-care centers.

"What makes this program work so well is that the students participating have encountered, maybe for the first time, peer support and support from an adult facilitator" who oversees the program, said Jane Paine, a consultant with the Danforth Foundation. The foundation, in addition to the Junior League of St. Louis and the St. Louis school system, provides money for Teen Outreach.

She added that many participants formed close ties with the people they helped through their volunteer efforts. "They begin to realize that postponing parenthood and finishing high school will allow them to accomplish more with their lives," she said.

Teen Outreach helps young people realize their options, set goals for themselves and encourages them to make conscious choices, said Mary Beth Ortwerth, program coordinator.

The program began in 1978 as a spinoff to the Parent Infant Interaction Program, a program for pregnant adolescents in the St. Louis schools. An independent evaluation of Teen Outreach done in 1982 by a researcher at St. Louis University showed the program had "significantly reduced pregnancy rates among its participants as well as increased the likelihood that its participants would complete high school."

AFL #

A Junior League spokeswoman said local leagues interested in starting pilot Teen Outreach programs could submit an application in the next few weeks. Between six and eight leagues will be selected, and they will get in-depth training and help to establish the program in their communities.

In the St. Louis area, about one in 11 teen-age girls become pregnant, according to a Danforth Foundation study made in June. In 1981, that number totaled 11,405 and cost taxpayers here $87.1 million in health and welfare aid.

In addition to discussing Teen Outreach, Marion Howard of Emory University in Atlanta outlined some of the pitfalls of teen-age pregnancy. She said those included increases in child abuse and neglect, health risks for teen mothers and their children, suicides and family instability.

— JP she could go to St Louis

She blamed today's social values, where sex is glamorized in the media and divorce is common, as contributing to the problem of teen-age pregnancy.

"Young people will see 500,000 advertisements by the time they graduate from high school," said Ms. Howard. "Many of these advertisements have sexual overtones, and they often portray sex as being hostile or manipulative.

"Studies have shown that what teen-agers watch on TV or in the movies or see in advertisements alters their perspectives on sex."

She said in Atlanta that a coalition of 27 community groups had begun the "Let's Talk Campaign for Responsible Parenthood," which has proven successful in decreasing teen-age pregnancies there. She said this program helped parents to talk to their children about teen sexuality and responsible parenthood.

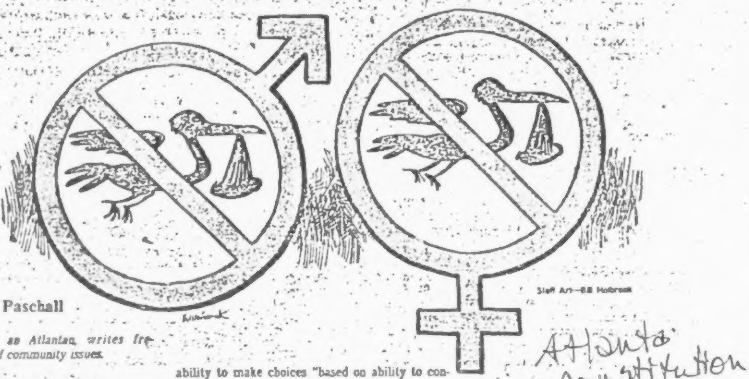
Out of that program, an educational series on "How To Say No" was developed to help young people resist pressures to become sexually involved before they were ready for such involvement.

"We found that 80 percent of sexually active teen-agers in our area wanted to learn how to say no without hurting the other person's feelings," she said.

The evaluation/research for this project has AFL funding

Teaching teens how to say 'no'

Program aims at curbing teen pregnancy rate



Staff Art—Bill Holbrook

By Eliza Paschall

Eliza Paschall, an Atlantan, writes frequently on an array of community issues.

Atlanta Constitution
5/27/83

While lawyers and judges continue to argue in court over the right of parents to be informed if their teenagers go to birth-control clinics, Atlanta is gaining national recognition for a program designed to involve parents in an effort to teach children younger than 16 that "you ought not to be having sex at a young age."

The Coalition for Responsible Parenthood and its education series — popularly known as the "Learning How to Say 'No' " series — is a program of the Teen Services of Grady Hospital, co-sponsored by 27 public and private institutions.

Dr. Marion Howard, director of Teen Services and an associate professor in Emory Medical School's Department of Gynecology and Obstetrics, says the program is a response to several facts.

It had been thought that if teenagers were taught sex education and were provided with contraceptive services, the teenage pregnancy rate would go down.

Atlanta's public schools have had a sound sex-education program for the eighth grade for six years now. Grady has provided birth-control information and services to metropolitan Atlanta teenagers for 12 years.

The teenage pregnancy rate has gone down some, but still one out of every eight girls in Georgia becomes pregnant while still of school age.

It had been thought that, given the facts, teenagers would consider the consequences of their actions. But now some psychologists theorize that under-18 year-olds have not developed the ability to make choices "based on ability to conceive the future."

In addition, it became apparent that programs and support systems in existence had been designed to support those teenagers who had decided to become sexually involved and who did choose to become pregnant. There was little help for teenagers who wished to postpone sexual involvement. There was little encouragement for parents who wished to help them.

Dr. Howard and her staff took a second look at these facts and concluded that knowledge is not enough to change behavior. "We know that from smoking," Dr. Howard said. "Despite knowledge on the dangers of smoking, people still smoke."

So what does govern behavior? Values? Dr. Howard and her staff surveyed the Atlanta community to find out if Atlantans were aware of the teenage pregnancy rate, whether it was perceived as a problem and what focus community wanted in programs dealing with the situation.

They learned that yes, the community was aware of the situation; yes, it does regard it as a problem; and it wants programs focusing on parental participation and postponing sexual involvement.

The Coalition for Responsible Parenthood, headed by Mayor Andrew Young and his wife, Jean, sponsored a "Let's Talk" series involving parents and teenagers. It was established that Atlantans value postponing sexual involvement. The "Learning to Say 'No' " series institutionalizes that value.

Most sex education programs, Dr. Howard says, present alternatives to teenagers, with the hope that they will act responsibly. "Our series avoids the double message implicit in such programs. It starts with a given value: You ought not to have sex at a young age, and everything is designed to reinforce that predetermined goal. The role-playing, for example, shows that you can say 'no' and be socially successful. The girl doesn' lose her boyfriends and the boy is not considere 'gay.' "

Parents are urged to "talk with your son and daughters about your religion, your belief your values, your feelings." Brochures to b mailed out to teenagers and their parents carr this message:

"Saying 'no' is the only 100 percent sure wa of preventing pregnancy and V.D. . . . Some di eases spread by having sex can't be cure . . . More and more grown-ups are finding the can't have a baby because of infection they g from having sex as teens . . . Girls and boys wh become parents while teens may not finish scho and be able to get a good job, may hurt or n take good care of their child, may have to be welfare, may not have healthy babies."

Dr. Howard believes that young teenage are called on to make decisions about sex wh decisions in other areas are made for them teenager who asks "should I become sexually in volved" is often answered with "it depends how you feel." When that same teenager as about drinking alcohol, taking drugs, driving car, voting — to name a few — nobody says depends on how you feel."

1983 - Field Testing

WHY?

Eight out of every ten boys has sex while still in their teens. One out of every eight girls in Georgia becomes pregnant while still of school age (under the age of 18).

WHAT CAN YOU DO?

TALK TO YOUR SON OR DAUGHTER

- ABOUT YOUR RELIGION, YOUR BELIEFS, YOUR VALUES, YOUR FEELINGS

GIVE YOUR SON OR DAUGHTER THE FACTS

- SAYING "NO" IS THE ONLY 100% SURE WAY OF PREVENTING PREGNANCY & V.D.
- SOME DISEASES SPREAD BY HAVING SEX CAN'T BE CURED
- MORE AND MORE GROWN-UPS ARE FINDING THEY CAN'T HAVE A BABY BECAUSE OF INFECTIONS THEY GOT FROM HAVING SEX AS TEENS
- GIRLS AND BOYS WHO BECOME PARENTS WHILE TEENS . . .
    - May not finish school and be able to get a good job
    - May hurt or not take good care of their child
    - May have to be on welfare
    - May not have healthy babies
- HEALTH CLINICS HAVE BIRTH CONTROL COUNSELORS AND SERVICES FOR TEENS WHO NEED THEM

MEMBERS OF THE ATLANTA COALITION FOR RESPONSIBLE PARENTHOOD

Atlanta Public Schools 659-3381
Atlanta Council of PTAs 659-3381 ext. 162
March of Dimes Birth Defects Foundation 325-9800
Emory/Grady Teen Services Program 588-4202
City of Atlanta, Office of Community and Citizen Affairs
  658-6347
Fulton County Teen Clinical Services 525-4981
State Council on Maternal and Infant Health 892-4241
Youth Agencies Collaboration
  Camp Fire Association, Inc. 525-7635
  Northwest Georgia Girl Scout Council 522-1160
  Metro Atlanta Girls Clubs 758-1467
  Big Brothers/Big Sisters 522-1241
  Girls Club of Cobb/Marietta 422-0999
  Metro Atlanta YWCA 522-9922
  Cobb County YWCA 427-2902

Council for Children, Inc.
Child Services and Family Counseling, Inc. 873-6916
Planned Parenthood of the Atlanta Area 688-9300
North Central Georgia Health Systems Agency, Inc.
Georgia Department of Family and Children Services
  656-6700
Society for Adolescent Medicine — SE Branch
Medical Association of Georgia 876-7535
Atlanta Southside Community Health Center, Inc.
  688-1350
Blue Cross/Blue Shield of Georgia 262-8269
Central Fulton Community Mental Health Center
  588-4771
Emory/Grady Family Planning Program 588-3700
Atlanta Medical Association 691-4808
Economic Opportunity Atlanta 525-4262

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LET'S TALK

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WHY A SERIES ON "HOW TO SAY NO?"

This series on "how to say no" was developed to help young people resist pressures to become sexually involved before they are ready for such involvement. The series is designed to provide young people with tools to help them bridge the gap between their physical development and their cognitive ability to handle the implications of such development.

The aim of this series is to present information regarding the general nature of relationships, sources of societal pressure influencing sexual behavior, and assertive responses which teens can use in peer pressure situations. This knowledge and these skills should help young teens deal with problem situations so that they can postpone sexual involvement until a time when they are better able to make decisions which have a long range impact on their lives. Parents who participate in the series receive similar information so that they can act as reinforcement agents.

WHAT ARE THE GOALS OF THE EDUCATIONAL SERIES?

The goals of the Postponing Sexual Involvement Series are:

1. To help young teens understand the pressures in our society which influence young people's sexual behavior.
2. To help young teens understand their rights in social relationships.
3. To help young teens deal with pressure situations through the use of assertive responses.
4. To help young teens postpone sexual involvement.
5. To help parents understand the pressures in our society which influence young people's sexual behavior.
6. To give parents tools to help young teens postpone sexual involvement.

WHAT DOES THE EDUCATIONAL SERIE
CONSIST OF?

SESSION I: SOCIAL PRESSURE

1½ Hours

Presentation of information and exercises re
ting to social pressure. This session promo
understanding of why some teens might beco
sexually involved to meet various needs. It inclu
information on how such needs could be bet
met in other ways.

SESSION II: PEER PRESSURE

1½ Hours

Presentation of information and exercises
lating to peer pressure. This session promo
understanding of peer pressure in group situati
and on a one-to-one basis.

SESSION III: PROBLEM SOLVING

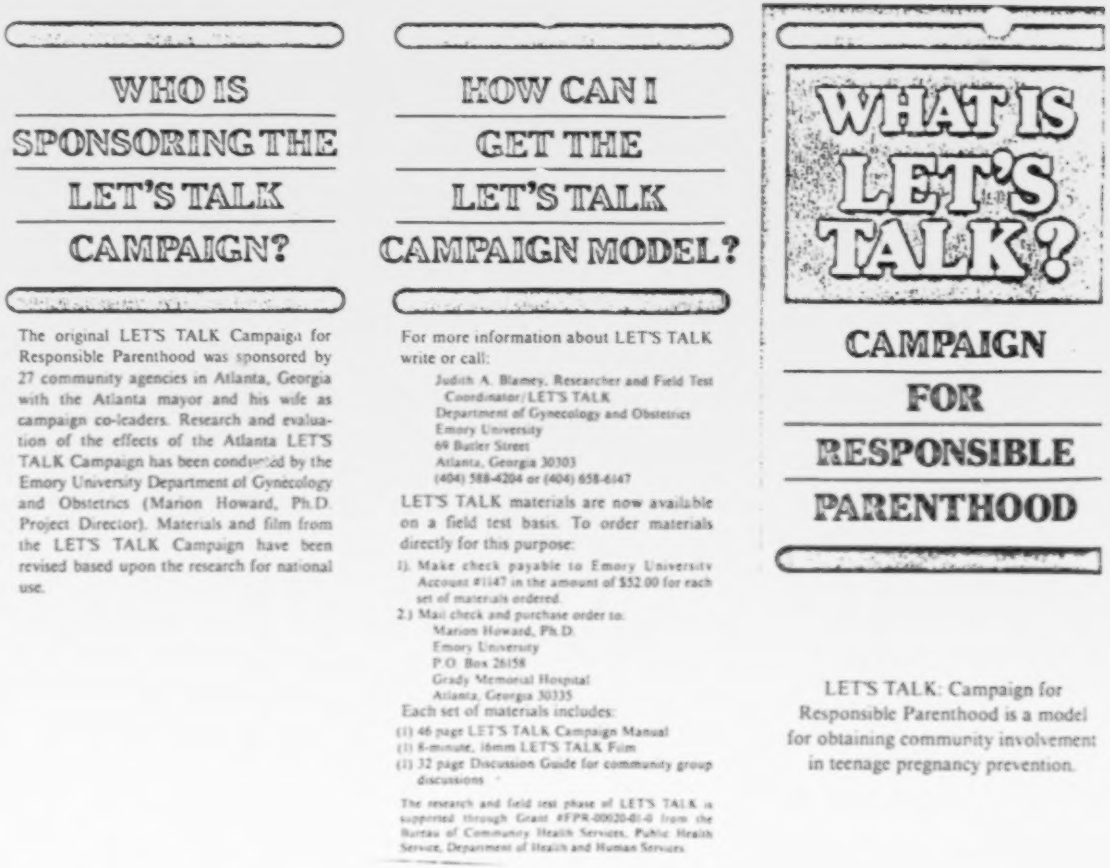
1½ Hours

Presentation of information and exercises
lated to problem solving. This session promo
understanding of ways to look at limiting
pressions of physical affection. It provides gu
ance in handling difficult social situations.

SESSION IV: USING NEW SKILLS

1½ Hours

Reinforcement sessions on using new sk
This session includes a review of skills. It prov
opportunities for additional skills practice. (T
session is held several months after the first thr
sessions.)



WHO IS SPONSORING THE LET'S TALK CAMPAIGN?

The original LET'S TALK Campaign for Responsible Parenthood was sponsored by 27 community agencies in Atlanta, Georgia with the Atlanta mayor and his wife as campaign co-leaders. Research and evaluation of the effects of the Atlanta LET'S TALK Campaign has been conducted by the Emory University Department of Gynecology and Obstetrics (Marion Howard, Ph.D. Project Director). Materials and film from the LET'S TALK Campaign have been revised based upon the research for national use.

HOW CAN I GET THE LET'S TALK CAMPAIGN MODEL?

For more information about LET'S TALK write or call:

Judith A. Blamey, Researcher and Field Test Coordinator/LET'S TALK
Department of Gynecology and Obstetrics
Emory University
69 Butler Street
Atlanta, Georgia 30303
(404) 588-4204 or (404) 658-6147

LET'S TALK materials are now available on a field test basis. To order materials directly for this purpose:

1). Make check payable to Emory University Account #1147 in the amount of $52.00 for each set of materials ordered.
2.) Mail check and purchase order to:
Marion Howard, Ph.D.
Emory University
P.O. Box 26158
Grady Memorial Hospital
Atlanta, Georgia 30335

Each set of materials includes:

(1) 46 page LET'S TALK Campaign Manual
(1) 8-minute, 16mm LET'S TALK Film
(1) 32 page Discussion Guide for community group discussions

The research and field test phase of LET'S TALK is supported through Grant #FPR-00020-01-0 from the Bureau of Community Health Services, Public Health Service, Department of Health and Human Services.

WHAT IS LET'S TALK?

CAMPAIGN FOR RESPONSIBLE PARENTHOOD

LET'S TALK: Campaign for Responsible Parenthood is a model for obtaining community involvement in teenage pregnancy prevention.

WHAT DOES A LET'S TALK CAMPAIGN CONSIST OF?

LET'S TALK is a community involvement campaign designed to begin a process of dialogue on youth problems and those consequences of youth problems that lead to teenage pregnancy and early (teen) childbearing.

LET'S TALK: Campaign for Responsible Parenthood involves:

1. Building a community coalition.
2. Using the media to increase community awareness.
3. Offering opportunities for community dialogue through small group discussions.
4. Improving adult (parent)/child communication about teen sexuality and responsible parenthood.

WHAT RESULTS CAN COME FROM A LET'S TALK CAMPAIGN?

Research has shown LET'S TALK can—

- Increase professional and agency/organization commitment to teenage pregnancy prevention
- Improve community awareness of the teenage pregnancy problem
- Promote opportunities for community dialogue, particularly among parents
- Secure a mandate from the community with respect to teenage pregnancy prevention focus and efforts
- Enhance parent/child communication

WHAT MATERIALS ARE AVAILABLE FOR A LET'S TALK CAMPAIGN?

LET'S TALK materials consist of:

A CAMPAIGN MANUAL on how to conduct a LET'S TALK Campaign from start to finish, i.e. from organizing the community to pre-and post-evaluation of the campaign.

An 8-minute discussion-starter FILM called LET'S TALK.

A DISCUSSION GUIDE for leaders to use in conducting community discussion groups.

EXAMPLES of possible campaign materials (buttons, bumper stickers, poly bags, etc.).

Senator **Denton**. I understand, Dr. Howard, that you have, in past presentations, used an analogy comparing drivers' education in the schools to illustrate the shortcomings of some sex education programs in the schools.

Could you review that concept of yours for us today, please?

Dr. **Howard**. I think the analogy that you are referring to was a statement that was one time made that being against sex education is like being against driver education. You assume that there will be more accidents on the roadway.

However, there was a study done in Michigan a number of years ago in which, after driver education was instituted, there were more accidents on the roadway. I want to say that I am a firm believer in sex education. What happened in Michigan I believe, was that after the institutioning of the driver education, parents felt that when their children passed that course, they could relinquish all their duties and responsibilities to assure that that young person knew how to drive, was maturely responsible and able to drive, had the necessary qualifications. In general, parents may have taken more trouble to assess such attributes before the driver education course.

I think it would be unfortunate if we instituted sex education programs in which the child came home and said, "I have had sex education," and the parents, therefore, assumed that they did not have to talk to their child about their values, that they did not have to talk to their child about their religious beliefs, that they did not have to talk to their child about what they wanted for their child, what their expectations were.

I think that certainly parents have a very, very important role to play in helping the child arrive at appropriate decisions. The analogy that I made was that we should not institute programs that would somehow indicate to parents that they no longer have their important role to fill.

Senator **Denton**. In an article in the St. Louis Post Dispatch, you were recorded as saying:

> Young people will see 500,000 advertisements by the time they graduate from high school. Many of these advertisements have sexual overtones and they often show sex as being hostile and manipulative.

In your experience counselling teenagers, you obviously encounter those who feel pressured to become sexually active and you mentioned the 80 percent who ask questions about how to say no without hurting the feelings of someone.

But have you also encountered those who have exhibited negative attitudes towards sex to the unusual kinds of stimuli you mentioned? In other words, could some teenagers be affected by the hostility, manipulation message in a way that would cause, in one extreme, a fear of sex or at least more commonly present interference regarding their ability to have normal interaction with those of the opposite sex, perhaps in courtship or even in marriage?

Dr. **Howard**. Well, there are some studies that show that young people who watch afternoon soaps on television, for example, tend to greatly overestimate the amount of sex among unmarried people and greatly underestimate the amount of sex among married people.

That seems to give us evidence that what they see does color their perceptions of reality, and the fact that they really do not see reality I think is a real concern to all of us.

Senator DENTON. How can or do you try to deal with those negative feelings and fears or their attitudes toward those role models, programs, and so on?

Dr. HOWARD. Well, basically what we help them do is look at the messages they are receiving from society about sex and help them examine those messages: the macho man or the liberated woman—with liberation being associated with being sexually free—look at where those pressures are coming from and begin to see that those are not accurate perceptions of really what exists.

Senator DENTON. Thank you very much for your perceptive, in my view, testimony. It has been a very valuable testimony, Dr. Howard.

Our next witness is Dr. Edmund V. Mech. I will ask him to come forward. He is a professor at the University of Illinois. He is the recipient of an AFL research grant and has examined the orientations of pregnancy counselors toward adoption.

STATEMENT OF EDMUND V. MECH, PH.D., PROFESSOR, UNIVERSITY OF ILLINOIS, DEPARTMENT OF SOCIAL WORK, URBANA, IL

Dr. MECH. Mr. Chairman, thank you for providing an opportunity to discuss our research on counselor attitudes toward adoption. A longer statement has been submitted for the record. I would like to highlight some of the main points.

Senator DENTON. Your statement will be included in the record as if read, without objection.

Dr. MECH. This study was based on the premise that much could be learned about adoption attitudes from persons who provide counseling services for pregnant adolescents. We were interested in mainly three areas.

One, attitude of the counselor toward adoption. Second, knowledge of counselor about adoption, and third, action—the willingness of counselors to take action on the adoption option in the counseling situation.

Accordingly three questions were raised. One, what attitudes do counselors have about adoption? Second, how accurate is their information? And third, what are the main techniques they use?

One hundred and thirty-two counselors in 94 agencies throughout Illinois were selected on a sampling basis. This group reported serving approximately 19,000 pregnant adolescents during calendar year 1982.

Each counselor was interviewed for approximately 1 to 1½ hours and answered questions in a number of areas related to adoption. The main results were:

One, counselors were far more positive toward adoption than they were about parenting as an option for adolescents. Counselors believed the parenting option to be the least desirable. Despite their personal beliefs about the risks associated with adolescent parenting, in actual practice counselors tended to support adolescent decisions to parent.

Second, counselor responses to questions about adoption were highly variable and very uncertain. Less than one in three counselors reported having a high degree of confidence in the accuracy of their adoption information.

Third, nearly 75 percent of the counselors identified the neutral approach as the most effective method with adolescents and indicated this method as being closest to their approach.

The main element in the neutral approach is the attempt to be objective, to give information only, and to try not to influence the adolescent for or against any one option.

The following observations are offered. First, counselors are essentially positive about adoption. For most counselors, adoption is clearly preferable to adolescent parenting.

Adoption appeals to counselors probably because adoption increases the chances of providing a stable and permanent home for the child and serves as a form of prevention against the risks of adolescent parenting.

Having a positive attitude toward adoption is one condition which counselors must meet in order for effective counseling to occur. Counselors earn high marks in this area.

Second, the area of adoption knowledge was quite another matter. Counselor information about adoption is too often inaccurate. Given the present state of the art, there is little guarantee that adolescents receive credible adoption information.

Counselors lack accurate information about adoption and are unlikely to have the knowledge to answer routine questions with informed confidence.

Third, another condition for adoption counseling to occur is that counselors must make reasonable efforts to insure that adoption receives equitable consideration in the decision process.

If one believes that the best service delivery system is one that offers adolescent parents and the child a wide range of options that can benefit both parties, adoption clearly does not command its fair share of the market.

Is counseling neutrality really the best method for conveying the adoption option to adolescents? I am convinced this is an issue worthy of serious debate. It was encouraging to learn that counselor attitudes toward adoption are essentially positive. However, counselors appear unsure as to whether a potential market exists even if they were to give increased emphasis to adoption in their counseling.

The research component of the Adolescent Family Life Act has much to offer in terms of contributing knowledge that can lead to improved adoption counseling. For example, it is important to determine how counselors and adolescent clients can be helped best to weigh alternatives and in the process to consider the best interests of the child as well as those of the mother.

Another area in which research is important is that of determining receptivity levels of adolescents toward adoption planning. Current programs are based on the assumption that nearly all adolescents are willing and able with enough support to assume parental responsibility. Limited adolescent interest in adoption is now taken as a given. There has been no objective attempt to determine from the adolescents themselves the conditions under which they might consider making an adoption plan.

If adoption planning is to gain ground among adolescents, then such an effort may be vital. Mr. Chairman, this concludes my oral presentation. Thank you for the opportunity to appear before this subcommittee.

As a grantee under the Adolescent Family Life Act, I hope this information is useful to your subcommittee. I will be happy to answer any questions that you might have.

Thank you.

[The prepared statement of Dr. Mech follows:]

STATEMENT
of
Edmund V. Mech

I am Edmund V. Mech, Professor, School of Social Work, University of Illinois at Urbana-Champaign.

Mr. Chairman: Thank you for providing an opportunity for me to appear today to describe our research on the "Orientations of Pregnancy Counselors Toward Adoption." This project was conducted by the University of Illinois at Urbana-Champaign under a grant from the Office of Adolescent Pregnancy Programs. Our investigation was based on the premise that much could be learned about the status of adoption planning from persons who actually provide counseling services for pregnant adolescents. Pregnancy counselors have contact with large numbers of adolescents, their families, and significant others. Moreover, counselors are aware of the values and concerns about adolescent pregnancy that exist in the communities they serve. Pregnancy counselors are in positions of potential influence; not in terms of actually making decisions for clients, but in terms of making certain that adolescents are provided equitable information on options such as adoption as a basis for arriving at an informed decision.

Our study attempted to learn about the state-of-the art of pregnancy counseling with special emphasis on counselor views toward the adoption alternative. Among the questions posed for investigation were: (1) What attitudes and beliefs do counselors have about adoption as a plausible alternative for pregnant teens? (2) What knowledge and information do counselors have about adoption? and (3) What are the main practices and procedures used by counselors in serving pregnant teens? Counselors throughout the state of Illinois were selected on a sampling basis. Ninety-four facilities serving pregnant teens were in the sample. The sample included counselors from social service as well as health facilities. All geographic regions in Illinois were represented. Interviews have been completed with 132 counselors, data analysis is in the final stage, and a technical project report is in preparation.

Information was collected from the 94 sample facilities on selected characteristics of counselors and adolescent clients. Pregnancy counselors are by no means a homogeneous group. Highlights from our characteristics data provides a perspective on the composition of the counselor sample in terms of education, numbers of adolescents served, workload patterns with regard to counselor/client ratios, agency policies on counselor qualifications, and counselor perceptions of community values and attitudes toward adoption.

(a) Education of Counselors. The majority of counselors were college graduates. Approximately half had completed a masters degree. However, the backgrounds of counselors varied widely with respect to area of educational specialization. Specializations included anthropology, journalism, nursing, biology, psychology, art, social work, real estate, public relations, and home economics.

(b) Adolescents Served. Counselors reported serving nearly 19,000 pregnant teens during calendar year 1982. Of this number, nearly 85% were served in health facilities. Only 15 in 100 were served in social service type facilities. Nearly 3/4 of adolescents served were classified as either low income or public assistance recipients. Counselor estimates of options chosen were available for 16,565 pregnant teens. Of this number, about 50% chose to parent a child, 46% chose to terminate the pregnancy, and 4% made an adoption plan. However for the teens who carried their child to term (N = 8,980), 92% chose to parent, and 8% made an adoption plan.

(c) Staffing Patterns. The ratio of pregnant teens served to number of counselors per agency varied from a low of 12:1 for social service agencies, to a high of 116:1 for health agencies.

(d) Counselor Qualifications. Overall, only 55% of the agencies reported having special qualifications for pregnancy counseling. Many health facilities lacked special requirements for counselors, especially agencies with high client to counselor ratios (i.e. 100:1).

(d) Community Attitudes Toward Adoption. Agencies were asked to take as a reference point the community area which they serve and to judge the extent to which that community was favorable, unfavorable, or neutral toward adoption as an option for pregnant teens. Adoption received overall ratings of 35% favorable, 40% unfavorable, and 25% neutral. By far the lowest level of favorable ratings toward adoption (about 20%) were noted in the health-oriented facilities. The perceptions of health facilities regarding community attitudes toward adoption are vital since in Illinois it is the health facilities that serve more than 80% of the pregnant teens. Therefore,

> agency perceptions of levels of community acceptance of adoption are likely to have an effect on whether or not adoption is discussed, as well as on how adoption is presented.

With respect to our project, a summary of results is provided for three questions considered central to the study. First, what attitudes and beliefs do counselors have about adoption? Second, what information do counselors have about adoption and how accurate is their information? Third, what are typical practices and procedures used in the counseling process?

The "ideal" counseling equation for adoption requires meeting three conditions: (a) Positive counselor orientations toward adoption planning as a plausible alternative for adolescents, (b) Information about adoption that is factually sound and which equips counselors with a knowledge base sufficient to handle routine questions with informed confidence, and (c) A capacity to engage in "active" counseling with adolescent clients sufficient to ensure that adoption receives equitable consideration in the decision process. Essential results for our three core questions are summarized as follows:

QUESTION ONE

What attitudes and Beliefs do Counselors have about Adoption?

Counselor attitudes toward adoption were studied two ways: (1) By use of a 100 item Counselor Orientation

Inventory, and (2) A series of case vignettes depicting pregnant adolescents. For each vignette counselors were asked to make a choice between all combinations of options, taken two at a time. Parenting, adoption, and abortion were the three options used with each vignette. The 100 item Counselor Orientation Inventory, consisted of 34 adoption items, 38 parenting items, and 28 abortion items. Counselors were far more positive toward adoption and abortion as options than about parenting for adolescents. The level of positive counselor support for each of three options was - adoption-74%, abortion-72%, and parenting-51%. Counselors consider the parenting option as undesirable for adolescents, and in terms of attitudes conveyed in the inventory indicate that adoption is a preferable option. Results derived from a separate paired-comparison analysis of counselor responses to adolescent vignettes supports the Counselor Orientation Inventory data.

Expressed in terms of mean cumulated point scores for the vignettes, counselor preference for each of three options was: adoption-27 points, abortion-24 points, and parenting-8 points. In effect, counselors preferred adoption (and abortion) to parenting by a decisive margin. The low point score (8 points) for parenting suggests that as a group, counselors have little conviction that parenting offers a desirable option for adolescents. However, despite personal beliefs about the risks associated with adolescent parenting, in actual practice, counselors paradoxically stand up as firm supporters of adolescent decisions to parent.

Despite general agreement among counselors that adoption is preferable to parenting for most adolescents, many variations were noted in counselor attitude toward specific adoption issues.

Percentage distributions of counselor responses to each of 34 adoption items are summarized in Table 1. Information is given for all counselors (N = 132), and separately for white counselors (N = 99), and for non-white counselors (N = 33). Examples of differences in attitude and belief are:

(1) Relatively few counselors believe that pregnant teens want information about adoption. The fairly low counselor expectation of receptivity among pregnant teens for adoption information probably influences counselors in presenting adoption as an alternative.

(2) A noticeable percentage of counselors believe that placing a child for adoption creates a lifetime of worry, pain, and guilt for the birth mother.

(3) Counselors are sharply divided regarding the effectiveness of open-records policies as a method of encouraging adolescents to consider an adoption plan.

(4) Counselors are not agreed about whether adoption is presented as an alternative, or whether adolescents are provided an opportunity to consider adoption against other options.

(5) Many counselors fail to make a distinction between agency adoptions, and adoptions arranged privately by lawyers or doctors.

QUESTION TWO

What information do counselors have about adoption?

Counselor responses to information type questions about adoption were characterized by varying degrees of uncertainty. Over a series of 10 items, uncertainty ranged from 9% to 32%. Variations were even larger when counselor's responses were analyzed separately with respect to social service or health facility. For example, in response to item 9 (Table 2) "My doctor said he could handle the adoption for me and that I wouldn't have to go through an agency, is this legal in Illinois?" Twenty-nine percent were uncertain or answered don't know, another 19% responded "No," the remaining 52% answered "Yes." Nearly 40% of counselors in health settings were "uncertain." Table 2 summarizes counselor responses to 10 questions about adoption asked by a pregnant teen (hypothetical case). Overall, less than 1 in 3 counselors reported having a "high" degree of confidence in the accuracy of their information about adoption. Moreover, nearly 41% of the counselors in health settings reported having a low degree of confidence in the accuracy of information about adoption.

QUESTION THREE

What are typical counselor practices with pregnant adolescents?

Counselors were asked to judge which of three counseling approaches were (a) most effective with pregnant teens (b) least effective, with pregnant teens and (c) which approach came closest to the method used by the counselor. The three approaches were designated Neutral, Active, and Supportive.

The Neutral approach was described as "counselor is mostly neutral, objective and professional; dispenses information but does not try to influence client for or against any option." The Active approach was described as "counselor assumes an active and directive part in attempting to influence client toward the option counselor thinks is in client's best interest." The Supportive approach was described as "counselor tries to support any decision a client makes, even when a counselor is genuinely concerned that a particular decision might be a mistake for a client." Overall, 75% of the counselors identified the neutral approach as the most effective with teenagers. The approach designated as least effective by a wide majority of the counselors was the active/directive style. Nearly 7 in 10 counselors chose neutral as the method closest to their approach. Table 3 summarizes for white and non-white counselors their preferences for each of three approaches.

The main difference was that non-white counselors were slightly less favorable toward the neutral style than were white counselors. Overall, neutral (non-directive) and supportive approaches characterize the practice of most pregnancy counselors, and are identified as the preferred methods, irrespective of type or level of education, race, or service setting. Although there is a slight tendency among non-white counselors toward using directive (active) approaches, by and large, the principle of client self-determinism is dominant among pregnancy counselors. Directive methods, are viewed as unworkable and unacceptable.

The following summary observations are offered:

Counselor Attitude Toward Adoption

1. Counselors are essentially positive about adoption. For most counselors adoption is clearly preferable to adolescent parenting. Even though adoption is not synonymous with pregnancy prevention, adoption appeals to counselors in the sense that it constitutes a form of prevention against the risks of adolescent parenting, for the child as well as for the birth mother.

2. Counselor knowledge about adoption

   Counselor information about adoption is inconsistent and is too often inaccurate. Given the present state-of-the art of pregnancy counseling, there is little assurance that adolescents uniformly receive accurate adoption information. Information deficiencies with respect to adoption are most likely to occur in health settings. However, if counselors sensed a "demand" from adolescents for adoption information, the situation could probably be remedied through traditional training channels.

3. Counselor Practices

Counselor adherence to a neutral non-directive, and essentially "value-free" style, seems insufficient to stimulate adolescent clients to consider adoption. Counselor neutrality (or perhaps reluctance) places much of the burden on the adolescent to indicate interest in discussing adoption. There may be concern among counselors that a neutral procedure of initiating discussion of adoption with adolescent clients would be threatening, invite resistance and impair the counselors ability to help.

4. Counselor Expectations for Adoption

Preparation of adolescents for parenting has emerged as the focal point for service delivery. Health facilities and social agencies are now geared to the expectations that fully 95% of the adolescents who carry a child to term will decide on the parenting option. Most counselors take the absence of overt adolescent interest in adoption as given, and proceed on the assumption that all teens are willing to accept the parent role, and indeed are entitled to do so without question or interference from state or community agencies. As a consequence, most counselors have low expectations for adoption, assume a passive attitude toward adoption, and discuss adoption only if a client asks. The strategy of placing the burden on the adolescent client assumes that adolescents who do not openly ask about adoption are not interested (or curious) about adoption, do not have questions about adoption, or have not been thinking about adoption. The meager evidence available suggests that many pregnant adolescents give some thought to adoption, and can cite persons they know who are adopted, or had adopted a child. The need exists for objective evidence on this topic.

5. Future Directions

It was encouraging to learn that counselor attitudes toward the adoption option are essentially positive. The term "positive" is used in a pragmatic sense, and refers only to adoption as a comparative alternative with respect to other options, such as adolescent parenting. Counselors work in the context of a consumer model, and are sensitive to the "market" so to speak - that is the options that are utilized by adolescents and supported by friends, families and communities. By virtue of their interview responses, counselors have expressed an inclination to encourage adolescents to consider the adoption alternative. However, they appear unsure as to the potential "market" for placing increased emphasis on adoption planning. The research component of the Adolescent Family Life Act has barely scratched the surface in terms of knowledge building related to optimizing the adoption alternative. Several directions appear to have research merit;

a) research to determine how counselors can help adolescents to look at the adoption alternative as one that may be in the best interest of the child, as well as for the mother.

b) experimentation in the controlled use of media in programs designed to heighten community awareness of adoption as a positive approach to family building. That is, large scale ("saturation") use of TV, radio, magazine, films and so on to help inform and shape community opinion about adoption, with the goal of achieving a more receptive and "normalizing" community environment for adoption. Stanford University, for example, has done exemplary research in studying the effects of mass communication techniques on changing community behavior with respect to the prevention of heart disease.

c) research is needed to determine the receptivity levels of adolescents toward adoption planning. Limited adolescent interest in adoption is taken as a given and current programs are based on the assumption that nearly all adolescents are willing (and able with enough support) to assume parental responsibility. Objective information

> on this topic would be useful to pregnancy counselors, especially those in health settings. Our group at the University of Illinois is conducting exploratory research on the topic of "Measuring Adolescent Receptivity Toward Adoption Planning." It is our intent to develop a measuring device that can be used in counseling facilities on a large scale basis. We began our research with a 20 item scale to measure receptivity toward adoption planning. Based on preliminary data from 302 adolescent mothers and pregnant adolescents we have narrowed our item cluster down to five (5) factors selected by adolescents as important pre-conditions in order for them to consider making an adoption plan.

Mr. Chairman, this concludes my prepared remarks. I want to convey to you and to members of the sub-committee my appreciation for the opportunity to share information about our adoption research. As a grantee under the Adolescent Family Life Act I hope this information is useful to your committee. I will be happy to answer any questions that you might have.

E.V. MECH
UNIVERSITY OF ILLINOIS
APRIL 24, 1984

SUPPLEMENTAL TABLES

TABLE 1 - ORIENTATIONS OF PREGNANCY COUNSELORS TOWARD ADOPTION

TABLE 2 - COUNSELOR RESPONSES TO TEN QUESTIONS FROM AN ADOLESCENT CLIENT ABOUT ADOPTION (HYPOTHETICAL CASE)

TABLE 3 - PREFERENCES FOR EACH OF THREE APPROACHES TO COUNSELING ADOLESCENTS AS EXPRESSED BY WHITE AND NON-WHITE COUNSELORS

TABLE 1

ORIENTATIONS OF PREGNANCY COUNSELORS TOWARD ADOPTION

	ADOPTION ITEM	COUNSELOR RESPONSES					
		ALL COUNSELORS		WHITE COUNSELORS ONLY		NONWHITE COUNSELOR ONLY	
		% AGREE	% DISAGREE	% AGREE	% DISAGREE	% AGREE	% DISAGREE
1.	Teens want adoption information	22	78	23	77	78	22
2.	Private adoptions are as good as agency adoptions.	23	77	20	80	33	67
3.	Pregnant teens under 16 should consider an adoption plan.	81	19	90	10	55	45
4.	Adoption information should be required in all teen programs.	96	4	97	3	91	9
5.	If Teen finds she can't be a good parent an adoption plan should be considered.	87	13	90	10	79	21
6.	Agencies are the most accurate source of adoption information.	88	12	90	10	85	15
7.	Pregnant teens do not see adoption as desirable.	84	16	85	15	82	18
8.	Friends and family of teens are usually negative about adoption.	75	25	76	24	73	27
9.	Counselors usually present adoption as a key option.	60	40	62	38	55	45
10.	Adoption should be discussed with teens only as a last resort.	5	95	1	99	15	85
11.	Before adoption is considered the baby's father should be given a chance to raise the child.	68	32	66	34	77	23

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	ADOPTION ITEM	COUNSELOR RESPONSES					
		ALL COUNSELORS		WHITE COUNSELORS ONLY		NONWHITE COUNSELO ONLY	
		% AGREE	% DISAGREE	% AGREE	% DISAGREE	% AGREE	% DISAGREE
12.	Open adoption is more attractive to teens.	51	49	55	45	39	61
13.	Families of teens have accurate information about adoption.	1	99	2	98	0	100
14.	Counselors see adoption as more desirable than abortion.	45	55	41	59	58	42
15.	Counselors have adequate information about adoption.	67	33	65	35	73	27
16.	Counselors dislike someone placing a child for adoption.	25	75	23	77	30	70
17.	Adopted children are unhappy.	5	95	1	99	18	82
18.	People in this community prefer adoption over abortion.	43	57	47	53	30	70
19.	Teens who make an adoption plan are socially and emotionally immature.	5	95	3	97	12	88
20.	Making an adoption plan creates a lifetime of worry and pain for the birth mother.	21	79	16	84	33	77
21.	Foster placements are about the same as adoptive placements.	9	91	7	93	15	85
22.	Teens who make an adoption plan will regret this decision later in life.	21	79	15	85	39	61

TABLE 1

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ADOPTION ITEM	COUNSELOR RESPONSES					
	ALL COUNSELORS		WHITE COUNSELORS ONLY		NONWHITE COUNSELO ONLY	
	% AGREE	% DIS-AGREE	% AGREE	% DIS-AGREE	% AGREE	% DIS-AGREE
23. Adoptive couples usually favor their biological child over their adoptive child.	10	90	9	91	12	88
24. Adoptive families help society by taking in homeless children.	69	31	66	34	76	24
25. Teens should be discouraged from an adoption plan because they will later think they made a mistake.	5	95	1	99	15	85
26. Most people question how a mother can make an adoption plan after giving birth to the child.	78	22	80	20	73	27
27. Counselors should always refer to a licensed placement agency rather than provide the information themselves.	72	28	73	27	70	30
28. Most pregnant teens want counselors to give them information about adoption.	53	47	55	45	48	52
29. Sooner or later a birth mother will look for the child placed for adoption.	14	86	10	90	27	73
30. Teens who make an adoption plan are usually mature in reasoning and decision making.	75	25	79	21	64	36
31. Adoption usually works out well for most children.	88	12	92	8	76	24

TABLE 1

ORIENTATIONS OF PREGNANCY COUNSELORS TOWARD ADOPTION

ADOPTION ITEM	COUNSELOR RESPONSE					
	ALL COUNSELORS		WHITE COUNSELORS ONLY		NONWHITE COUNSELO ONLY	
	% AGREE	% DISAGREE	% AGREE	% DISAGREE	% AGREE	% DISAGREE
33. Adoption is a risky option because it has undesirable effects on the birth mother and the child placed.	12	88	9	91	21	79
34. When a 15 year old pregnant teen says "If I'm going to be pregnant for 9 months I'm going to keep my baby." The counselor should go along with her wishes.	44	56	42	58	48	52
35. A licensed placement agency is the best source of adoption information.	90	10	90	10	91	9

TABLE 2

COUNSELOR RESPONSES TO QUESTIONS ABOUT ADOPTION FROM A PREGNANT TEEN (HYPOTHETICAL CASE)

	Question from Pregnant Teens	Counselor Response		
		"Yes"	"No"	"Uncertain/ Don't Know
1.	"Will I be told whether or not my child is actually placed for adoption?"	81.7%	5.3%	13%
2.	"Will an agency tell me what the adoptive family is like?"	80.2%	7.6%	12.2%
3.	"Will I be able to visit my child after he/she is adopted?"	2.3%	83.1%	14.6%
4.	"Will I be able to meet and talk to the family that wants to adopt before I actually make a decision?"	13.0%	62.6%	24.4%
5.	"Does my boyfriend have any rights to the child if I make a final decision about adoption?"	69.5%	15.3%	15.2%
6.	"If I choose adoption will all of my medical expenses be paid?"	49.6%	18.3%	32.1%
7.	"If I choose adoption will I be notified when the decree is final?"	58.3%	16.7%	25.0%
8.	"If I choose adoption and go through an agency will the hospital expenses be paid?"	56.1%	11.4%	32.6%
9.	"My doctor said he could handle the adoption for me and that I wouldn't have to go through an agency. Is this legal in Illinois."	52.3%	18.9%	28.8%
10.	"If I choose to make an adoption plan will I have a chance to change my mind before the placement is final?"	75.8%	15.2%	9.1%

TABLE 3

Preferences for each of Three Approaches to Counseling Adolescents as Expressed by White and Non-White Counselors

Perceived Utility of Method		Counseling Approach		
		Neutral	Active	Supportive
Most Effective	White	72%	8%	20%
	Non-white	77%	7%	16%
Least Effective	White	6%	78%	16%
	Non-white	19%	65%	16%
Method used by Counselor	White	72%	9%	19%
	Non-white	57%	20%	23%

Senator **Denton**. I assure you, Dr. Mech, that it is useful and quite newly informative to me. I am impressed particularly by your rather firm conclusion that the knowledge of counselors regarding adoption is relatively low. That seems to be one of your firmest conclusions.

You said in the written statement, "If counselors sensed a demand from adolescents for adoption information, the situation could probably be remedied through traditional training channels." Lacking that, what would you suggest? It seems that you are inferring that since there is not a demand from adolescents for adoption information, you cannot train the counselors to know more about adoption.

Dr. **Mech**. There are two approaches I think you can take, maybe more. The one I am looking at is I do not think counselors are going to be as receptive to training if they do not think there is a market for it.

In fact, that is probably one reason that adoption is not being utilized. Counselors are not as up on adoption information as one could expect. They do not think there is receptivity from the market; hence it is not usable to them.

To give training in the absence of some convincing evidence that there is a market I think would be useful. They should have it, but I do not think they are connected to it now.

Senator **Denton**. I guess implicit in what you say is that there is really a market for adoption in that there are a great number of potential adoptive parents waiting to realize their desire, but in the other sense, the teenagers do not demand from the counselors information in that direction because it is not their own disposition.

I conclude that you are in favor of doing something about filling that knowledge gap on the part of counselors and that they should know more about adoption.

Dr. **Mech**. Well, it seems somewhat clear to me that counselors are hesitant about checking out whether the adolescent client is interested in adoption. In other words, the burden is on the adolescent client to come in and open it up.

My point is that if we had more information through the research part of the Adolescent Family Life Act that this might be a logical area because counselors are very aware of the market, Senator. In a sense they think they know what their communities believe and they also think they know what the adolescents believe, and they think they most want to take the parenting option.

Senator **Denton**. In your written testimony you also have this statement. "The level of positive counselor support for each of the three options was adoption, 74 percent; abortion, 72 percent; and parenting, 51 percent," which to me is an interesting set of percentages.

You state in the progress report submitted to the Office of Adolescent Pregnancy Programs that 25 to 40 percent of pregnancy counselors believe that placing a child for adoption results in a lifetime of pain, worry, and guilt for the mother.

Do any of the counselors that you interviewed seem to have the same perception about abortion?

Dr. **Mech**. Yes. The point I think I was trying to make is this that the counselors see options other than parenting as being the more desirable route. In other words, they are definitely not for the adolescent parenting option. They are all for prevention.

Senator **Denton**. Do you feel that the Adolescent Family Life Programs as they presently exist can help to reverse some of these perceptions about adoption or are you emphasizing that perhaps—of course, you do not know all the research projects that we have going, but certainly you have made a good suggestion—but do you feel that as they presently exist these programs might help reverse some of the perceptions about adoption?

Dr. **Mech**. Yes.

Senator **Denton**. Well, that has certainly been the intent of the author of the bill. We will study very carefully what you have submitted. It is most interesting and relevant. You have broken up your statistics by race and teens and the counselor responses to different questions. You even have the counselor's perceptions of most effective and least effective methods respecting the neutral method, the active method, and the supportive method. We value your findings and shall be corresponding with you and thank you very much for your testimony this morning, Dr. Mech.

Dr. **Mech**. Thank you, Mr. Chairman.

Senator **Denton**. Our final witness—and I want to thank her for her patience; she is not least though she is last—Dr. Janet Hardy, the Director of Children and Youth Program, at Johns Hopkins University in Baltimore.

She, too, is the recipient of an Adolescent Family Life research grant and has examined the use by pregnant adolescents of resources in the community. I want to thank you for coming today, Dr. Hardy, and again, for your patience.

Please begin.

STATEMENT OF JANET HARDY, M.D., DIRECTOR, CHILDREN AND YOUTH PROGRAM, JOHNS HOPKINS HOSPITAL, BALTIMORE, MD

Dr. **Hardy**. Senator Denton, thank you very much for inviting me. It has been interesting to listen to the people who came ahead of me.

I have been requested to talk particularly about the current research project that you have just mentioned. It is in line with comments made by Dr. Brandt and Mrs. Mecklenburg this morning about the importance of evaluating the effectiveness of the kind of care that adolescents receive, not only the effectiveness but also the cost and ultimately the cost benefits of the use of various resources available to the young mothers and their infants from public and private agencies as well as from the young fathers, families, and friends.

We are measuring effectiveness in terms of both the immediate pregnancy outcome and longer range outcomes of the young mother and child. Included among these outcomes are those of the pregnancy itself, the subsequent health of mothers, of infants, the completion of education, marriage and separation and divorce, the occurrence of subsequent pregnancy and its resolution, employment, income, welfare dependency, and also the child's development over the 15-month period of followup in the study.

We are also looking at the reasons for timely use and nonuse of various services and barriers to obtaining services such as prenatal care, for instance.

The research subjects represent a stratified random sample of all births to women under 18 years, in Baltimore in 1983, and thus it covers a range of social classes and both black and white families.

After an elaborate informed consent process, the young mothers are interviewed at 3 months and 15 months after delivery to determine the outcomes, the resources and the barriers.

The study, because it is based on a random sample of all births, can provide objective, unbiased examination of the problems of adolescent pregnancy and the effectiveness and costs of various levels and types of service which provide care, including services that have been provided at Hopkins.

The preliminary results from interviews with black adolescents, and this is because there were many more black adolescents than white and so we had a sufficient number of interviews to work with, 3 months after delivery make the following points:

About 80 percent of the girls were not using contraception when they became pregnant though many of them had been sexually active for months before they became pregnant. Those girls who received care in the hospital-based comprehensive programs, of which there are two in Baltimore, had fewer complications of pregnancy, fewer C-sections, and considerably fewer low birth weight infants, and these three problems all add greatly to the cost of care. In my view, comprehensive programs are effective because they offer a range of needed services, because of individual case management with followup, and because of health, family planning, parenting, and child care education offered. I would like to make two or three comments about testimony presented this morning, if I may. One is that I am sure the subcommittee——

Senator DENTON. Since your time is up on your statement, I will consider this, in all fairness to the others, as an answer to the question, "Do you have any comments about the testimony offered before you this morning.?"

Dr. HARDY. Thank you for bailing me out.

I am sure the subcommittee is aware that there are many different populations of pregnant, parenting, and sexually active adolescents in the United States and that their management requires rather different approaches.

The special needs of black, poor, inner-city adolescents did not seem to be mentioned very much this morning, though they make up a very large portion of the cost of the problem.

I think that was the main point that I saw. You have been asking people if they would like to see the legislation changed in any way. You are right on target in terms of family involvement. That is very important, but I would rather see the legislation urge family involvement rather than mandate it.

One of the findings from our resource use study was that a number of girls did not seek prenatal care and did not seek contraceptive services before they got pregnant because they were afraid their families would find out, and they were afraid of family retribution.

Our experience with a pregnancy prevention program has shown that half of the girls who come request confidentiality at the first visit, but after the educational process has taken place and, by the time they come back a month later, most of them have talked with their parents and the mandating really is not necessary.

Thank you.

[The prepared statement of Dr. Hardy and responses to questions of Senator Denton follow:]

PREPARED STATEMENT OF JANET B. HARDY

The testimony to be offered on this occasion comes from more than 10 years experience with adolescent pregnancy, parenting and pregnancy prevention at the Johns Hopkins Hospital. During that period over 3,000 pregnant girls under 18 years of age have received care in a special adolescent pregnancy program and some 1500 mother-child pairs have been enrolled in the intensive three year follow-up program which provides continuing primary and preventive health care for both mothers and children, an extensive health and parenting educational curriculum and psychosocial support with referral to community agencies for other needed service.

Baltimore has the dubious dinstinction of having the highest rate of adolescent pregnancy, female headed, single parent families and sexually transmitted disease of any city of its size in the country. See Table 1 for estimated costs.

The information provided in this testimony comes from service oriented research in several related areas:

1. The cost-effectiveness of providing comprehensive services to pregnant and parenting adolescents;

2. Pregnancy prevention;

3. The study of several hundred parents of seventh graders at a large, inner-city junior high school to determine their knowledge of and attitudes with respect to marriage, reproduction and contraception, their communication with their children about these issues and their attitudes toward sex education in the schools;

4. Research involving the frequency of sexually transmitted disease in pregnant and non-pregnant adolescents;

5. Research involving resource use by pregnant and parenting adolescents.

Following a brief introduction, findings from each area will be briefly discussed.

Adolescents 17 and under accounted for approximately 20% of first births in Baltimore City in 1982 and mothers less than 20 years accounted for 45% of first births, eighty-five percent of adolescent births were out of wedlock. In our experience most were unplanned and many unwanted.

Approximately half of Baltimore's adolescent mothers do not finish high school. In today's economic climate, teenaged mothers who fail to finish school have a very difficult time supporting themselves and their children. Moore and others at the Urban Institute have determined that women who were teenaged mothers account for more than half of the families receiving AFDC. In addition, teenaged mothers and their children more often have health problems and faulty nutrition.

Our studies indicate that the children of adolescents are at particular risk of developmental delay, school failure and repetition of the adolescent pregnancy cycle. Currently, among the 18,000 poor East Baltimore children enrolled in the Johns Hopkins Children and Youth Program, 68% have mothers who had their first birth as a teenager, about 40% as an adolescent. A rough and preliminary estimate of the societal costs for the pregnancy and the first year after birth is presented in the table which follows.

TABLE 1

A preliminary and rough estimate of average costs for adolescent pregnancy care and for mother and infant for one year post-natally in Baltimore.

OBSTETRICAL CARE	
Comprehensive prenatal care, 10 visits X $90 each (includes x-rays, lab work, etc.)	$ 900
Labor and delivery: normal delivery $900 (80%) caesarean section $1,200 (20%)	940
Post-natal hospital care: normal delivery, mother and child $1,300 C. section (7 days) mother and child $2,000	1,440
WIC for pregnant girl ($32.70 X 7 months)	229
POST-NATAL CARE	
Well baby pediatric care - 6 visits at $30/visit	180
Sick child care - 4 visits at $50/visit	200
Maternal outpatient visits - 4 at $30/visit	120
Maternal sick care - 4 visits at $100/visit	400
AFDC payments ($230/month X 12 months)	2,760
Food stamps - for baby ($26/month X 12 months)	312
Infant family day care ($7.30/day X 180 days)	1,314
TOTAL	$8,815

There were 1,470 births to girls of 17 years and below in Baltimore in 1982 for a total of $12,958,050.

The above figures do not include repeating a grade in school ($2,683), additional special educational services, single parent social services, juvenile justice and protective services, foster care, adoption services, repeated pregnancy (10%/year), maternal illness and child illness requiring hospital care, child neglect and abuse, neonatal care for low birthweight infants can cost $100,000 to $200,000.

Contraceptives ($8.00/cycle X 12 months) = $96.00

Cost-Effectiveness of Comprehensive Adolescent Pregnancy Programs

The Johns Hopkins Adolescent Pregnancy and Parenting Program began 10 years ago and has served as a model hospital based comprehensive program, the need for medical care serving as the entry point. In addition to medical care, emphasis is placed on the importance of health, nutrition, pregnancy and parenting education presented in a group discussion, values clarification format to encourage learning through participation and the development of adolescent responsibility. Individual counseling of adolescents and family members is also provided and a social worker assures referral to community agencies for needed services. The need to complete one's education is stressed. Many young fathers attend educational groups and counseling sessions. Between 300-400 adolescents deliver each year.

After delivery, about 60-65% of the young mothers and their infants, the most high risk and youngest mothers, enroll in the Teenaged Clinic (TAC) for follow-up. The clinic provides continuing primary and preventive health care for mothers and infants (and a few fathers). For three years after birth health, family planning and parenting education are emphasized. A social worker provides counseling and referral for services.

Young mothers and infants who are not enrolled in TAC are enrolled in the Hopkins Children and Youth Program, a similar but less intense service or referred to other community resources. About 1200 mother-child pairs are currently enrolled in TAC.

Computerized data bases facilitate program monitoring and evaluation. Similar adolescents delivered at Johns Hopkins but receiving prenatal and follow-up care in other programs have served as comparison groups for evaluation studies. Data from two separate evaluation studies are presented.

The first evaluation was carried out using births in 1976-77 with mothers and infants followed 24 months. The data are shown in Tables 2-5 (pages 2a, 2b and 2c). Not only was the sepcial program effective in improving the health of adolescent mothers and children, reducing the frequency of early repeat pregnancy and in helping girls graduate from high school as compared with controls, it was highly cost-effective. The program costs, over and above routine medical care costs, were $775 per mother-child paid for the pregnancy and the two year follow-up as compared with averted costs (cost savings as compared with the experience of controls) of $1,440 - in 1979 dollars.

The second evaluation study was carried out using births in 1979 and 1980. The comparison group was the Hopkins Comprehensive Care Clinic which also provided prenatal care and follow-up medical care for mothers and babies, separately, after delivery. This program had no formal educational curriculum and social service was available only on a crisis basis. Community linkages were less effective. Nontheless, it was similar to many comprehensive programs.

The results of this evaluation, which did not include welfare support are shown in tables 6-12 (pages 2d through 2h).

Table 2

Frequency of Complications of Pregnancy, Labor and Delivery in 466 Black HAC and 1004 Other Black Adolescents Delivered at Johns Hopkins, 1976 and 1977

HAC - The Johns Hopkins Adolescent Pregnancy Program

CONDITION	HAC (n=466) Percent	OTHERS (n=1004) Percent
Prenatal		
Preeclampsia Toxemia	5.7	12.1**
Pyelonephritis, UTI	8.0	15.6**
Neuro-psychiatric	0.8	2.5**
Venereal Disease	7.9	10.6
Height (60 in. and below)	18.9	13.6
Weight gain (10 lbs. or less)	9.7	8.6
More than 12 prenatal visits	15.2	25.5
Labor and Delivery		
Cesarean section	11.7	14.7*
Cervical laceration	2.8	4.2
Pregnancy Outcome		
Stillbirth	0.63	1.3**
Neonatal death	1.1	3.3**
Perinatal death	1.7	4.7**
Short gestation (less than 37 wks.)	11.6	14.7*
Birthweight below 2500 gms.	14.7	14.7
Resuscitation	11.9	15.2*

** $p < .001$

* $p < .01$

TABLE

FOLLOW-UP:
JOHNS HOPKINS ADOLESCENT PROGRAM
FIRST EVALUATION

	PERCENT	
	FOLLOWED *	OTHER HAC **
EDUCATION		
Attending school	39.5	35.9
Comp. 12th grade	42.1	20.6
MARRIED	19.5	10.9
WELFARE DEPENDENT	46.0	68.0
EVER WORKED	76.8	52.1
CHILD CARE		
Biologic mother at night	80.5	87.0
Biologic mother in day	48.7	74.5
Grandmother in day	29.3	14.8
REPEAT PREGNANCY		
In 12 months	7.5	21.0
In 24 months	25.0	39.0
DIFFERENT FATHERS	28.6	42.9
MEDICAL CARE: MOTHER		
Hospitalized	22.0	39.1
Acute ambulatory	35.0	45.7
Family Planning Clinic	98.7	65.2
Never used F.P.	1.3	11.1
MEDICAL CARE: CHILD		
All immunizations	98.8	85.1
Hospitalized	20.7	38.3
AVERAGE NO. ACUTE VISITS	4.2	6.1

* TAC - Teenaged Clinic for adolescent mothers and infants.

** Other HAC mothers and infants referred out to community clinics (Family Planning and well baby for follow-up).

TABLE 4

JOHNS HOPKINS ADOLESCENT PROGRAM

Incremental Costs Incurred (1979 Dollars)*

FIRST EVALUATION

PRENATAL	$190
• Social service	
• Psychological/educational screening	
• Educational program	
DELIVERY	$140
• Special nursing care	
FOLLOW-UP PROGRAM	$425
• Postpartum visit	$25
• Maternal health and family planning	125
• Child health, social service, education	275
	$775

* Routine medical care costs excluded

TABLE 5

JOHNS HOPKINS ADOLESCENT PROGRAM

Incremental Cost Benefit—2 Years *

FIRST EVALUATION

	Number	Expected Cost Averted
• Reduction in emergency services (child)	2 visits	$100
• Reduction in hospitalization (child)	1 day	160
• Reduction in hospitalization (mother)	2 days	170
• Reduction in Caesarean section		60
		$490
REDUCTION IN WELFARE • Differential probability of welfare cost of $1820/year	.21	760
REDUCTION IN REPEAT PREGNANCY COST • Differential probability of repeat pregnancy	.15	190
		$1440

* Estimates are based on comparisons between adolescents in the special programs and controls as indicated in tables 2 and 3.

SECOND EVALUTATION

TABLE 6 THE JOHNS HOPKINS ADOLESCENT PROGRAM: PREGNANCY VARIABLES

1979-1981	JHAPP n = 744		Others n = 744		
	Mean	Percent	Mean	Percent	P.
Prior Pregnancy:					
Abortions		11.6		11.4	ns
Births		7.4		10.3	ns
Weeks Gestation:					
At registration	17.30		17.04		ns
$\leq$ 12 weeks		15.9		17.8	ns
Gonorrhea		7.9		5.4	ns
Lowest hct., mm.	32.50		31.82		$<.001$
Hct. <30 mm. (anemia)		10.9		15.6	$<.002$
Toxemia		3.5		5.9	$<.02$
Weight gain	28.89		23.47		$<.0001$
No. pernatal visits*	9.22		8.67		$<.006$

*Does not include diagnostic visit

TABLE 7 THE JOHNS HOPKINS ADOLESCENT PROGRAM: LABOR AND DELIVERY

1979-1981	JHAPP n = 744		Others n = 744		
	Mean	Percent	Mean	Percent	P.
Gestation age, wks.	38.48		38.41		ns
Gestation, $\leq$ 36 wks.		18.6		21.5	ns
C. Section		17.1		19.5	ns
C. Section, $\leq$ 14 yrs.		0.5		1.7	$<.04$
P.R.O.M. >12 hrs.		3.3		5.5	$<.02$

SECOND EVALUATION

TABLE 5

THE JOHNS HOPKINS ADOLESCENT PROGRAM: FETAL OUTCOME 1979-1981

	JHAPP n = 744		Others n = 744		
	Mean	Percent	Mean	Percent	P.
Birthweight, gms.	3083		3038		ns
<2500 gms.		9.9		16.4	<.0006**
<1500 gms.		1.9		3.9	<.02 **
Apgar, 1 min.	7.87		7.68		<.03
5 min.	8.81		8.71		<.04
≤6 at 5 min.		4.0		6.7	<.02**
Congenital malformation*		4.9		7.0	ns
Stillbirth		1.2		1.0	ns
Neonatal death		0.4		1.2	<.08
Hospital days	4.9		6.0		<.05**

*Also includes minor malformations

** These are high cost indicators.

TABLE 9: ACUTE HEALTH CARE - MOTHERS AND CHILDREN

INPATIENT UTILIZATION OF ADOLESCENT MOTHERS, BY YEAR AND CLINIC

	JHAPP			CCCC			
	N	n	(%)	N	n	(%)	
First Three Years Following Index Birth	69			59			
One or more admissions		21	(30.4)		28	(47.5)	P<.05
One or more pregnancy-related admissions		16	(23.2)		19	(32.2)	N.S.
One or more admissions not related to pregnancy		6	(8.7)		11	(18.7)	P<.10

Mean Number of Out-Patient Illness-Related Visits Made by Children in the First Two Years of Life, by Clinic

Clinic Site	JHAPP (n=97)	CCCC (n=104)
TAC/CCCC	5.4	12.4
Other	0.9	0.3
All Clinics	6.3	12.7

Inpatient Utilization of Children, by Year of Life and Clinic

	JHAPP			CCCC			
One or More Admissions	N	n	(%)	N	n	(%)	
In First Year of Life	268	21	(7.8)	231	25	(10.8)	N.S.
In Second Year of Life	197	3	(1.5)	172	6	(3.5)	N.S.
In Third Year of Life	69	8	(11.6)	59	6	(10.2)	N.S.
In First Three Years of Life	69	12	(17.4)	59	9	(15.3)	N.S.

TABLE 10 Completeness of Well Child Care and Immunization Status of Children in First Two Years of Life, by Clinic

	JHAPP (n=97)	CCCC (n=104)	
Proportion of Children Having a Well Child Visit At:			
2 weeks	(89.7)[1]	(98.1)	$p<.02$
2 months	(98.9)	(97.1)	
4 months	(91.8)	(92.3)	
6 months	(94.8)	(86.5)	$p<.05$
9 months	(91.8)	(76.0)	$p<.005$
12 months	(95.9)	(79.8)	$p<.001$
15 months	(83.5)	(79.8)	
18 months	(90.7)	(74.0)	$p<.01$
21 months	(77.3)	Not Required	
24 months	(92.8)	(56.7)	$p<.001$
Proportion of Children Who Missed: [2]			
No well child visits	(60.8)	(31.7)	
One well child visit	(26.8)	(27.9)	
Two well child visits	(7.2)	(19.2)	
Three or four well child visits	(5.2)	(21.2)	
Proportion Having All Immunizations Required in First Two Years of Life	(89.4)	(74.0)	$p<.005$

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[1] No 2 week visit in JHAPP prior to 1980.

[2] 21 month visit excluded. (This visit was not required in the CCCC program.) Not required in JHAPP prior to 1980.

TABLE 11 **Reported Sources of Income[1] at the Time of the Interview, by Clinic**

	JHAPP (N=82)		CCCC (N=84)		
Source	n	(%)	n	(%)	
Respondent's Employment	13	(15.8)	10	(11.9)	
Unemployment Compensation	0	(-)	2	(2.4)	
Husband's Employment	1	(1.2)	3	(3.6)	
Father of the Baby	16	(19.5)	5	(6.0)	p<.02
Respondent's Parent(s)	13	(15.9)	16	(19.0)	
Other Relatives	2	(2.4)	2	(2.4)	
Social Security	3	(3.7)	7	(8.3)	
Department of Social Services	71	(86.6)	66	(78.6)	

[1] Sources of income are not mutually exclusive.

COST-EFFECTIVENESS

TABLE 12 **Program Difference in Per Enrollee Charges for Selected Services[1]**

Service	Difference in Charges (CCCCminus JHAPP)
Birth Hospitalization	$ 397.
Hospitalizations - child	22.
Hospitalizations - mother	261.
Emergency Services - mother	90.
Out-Patient illness use - child	143.
Well child care	- 66.
Net Difference	$ 847.

[1] For the pernatal period and the first two years following birth of the index child.

In summary, these results are similar to or better than those of the first evaluation. The frequency of low birthweight infants in JHAPP girls had fallen from 14.4% in 1977 to 9.9%, while the frequency of low birthweight in the Comprehensive Care Clinic remained at 16.4%, probably related in part to the average weight gain in pregnancy of almost 30 pounds for JHAPP as compared with an average of 23 pounds in CCC. Good weight gain reflects the availability of WIC and other food and nutrition education.

This evaluation also demonstrated the improved health of mothers and infants in JHAPP in the three years after birth as compared with those in CCC. These improved outcomes resulted in a cost savings of $847 per mother-child pair.

Pregnancy Prevention

A privately funded, three-year, combined research and service demonstration program is being carried out in a large senior high school and an equally large junior high (about 1800 students in all) close to Johns Hopkins. Classroom family living and sex education and individual and small group counseling is carried out by a social worker and nurse practitioner assigned in the mornings to each school. The same staff work in a "store front" clinic in the afternoons. Students from the schools may drop in for educational groups, educational movies, games and counseling after school and by appointment for family planning services. There are about 200 visits per month of which 140 are for family planning services. It is of interest that as many boys as girls come from the junior high - but only about 15% of boys from the senior high.

From this program we have learned that:

a. 50% of 7th graders have had intercourse at least once.

b. 18% of junior high females have been pregnant at least once.

c. there was initially little information and many misconceptions about sexuality among students.

d. the program led to improved knowledge and significantly improved contraceptive use among the sexually active students after one year.

e. after one year, there was a reduction in the number of abortions reported by the students - it was too soon to tell about births.

f. students reported little communication from parents about puberty, sexuality, etc.

g. a federally supported study of parents of 7th graders, by means of an interview conducted at home, indicated that parents knew almost as little about these issues as their children. Only 12% had sufficient information to protect their own fertility. These parents overwhelmingly (94%) supported sex education in the schools.

h. 50% of students requested at the first family planning visit that it be kept confidential but after two to three months most had told their parents about it. A small percentage feared severe retribution and were unable to tell parents.

Sexually Transmitted Disease (STDs)

Studies of the frequency of STDs among pregnant and non-pregnant but sexually active adolescents attending Johns Hopkins' programs indicate extraordinarily high frequencies of these gynecological infections. During pregnancy, 12% had gonorrhoea, 37% had Chlaymdia trachomatis, 34% had trichomonas, and 37% candida on culture. Non-pregnant girls had similar frequencies of gonorrhoea, and only slightly lower frequencies of other infections. These infections may have serious consequences for the infants, who are infected during birth and for the mothers health at later points in time. They add considerably to the overall costs of adolescent pregnancy and childbearing.

Resource Use by Pregnant and Parenting Adolescents

Preliminary findings from this study of a randomly selected sample of adolescents, delivering a baby in 1983 in Baltimore, clearly indicate that those fortunate enough to receive care in a comprehensive program have more favorable outcomes than those who receive care in community hospitals or HMOs or no care at all. Undoubtedly, because of fewer costly health problems and more effective prevention of subsequent pregnancies, overall costs will be considerably less for mother-child pairs receiving comprehensive care. However, the study is not yet complete and specific costs have not yet been addressed.

A copy of a presentation by Anne Duggan, Project Director, providing a description and preliminary results follows (Appendix 1).

Janet B. Hardy, M.D., P.I.
APPENDIX 1

FAILURES IN RESOURCE UTILIZATION

Anne K. Duggan

PRESENTED AT A SYMPOSIUM ON ADOLESCENT PREGNANCY
December 1983

1. Introduction

Let me begin by saying I am grateful for this opportunity to acquaint you with the methods and current activity of a three year study we are conducting with the Baltimore City Health Department.

As you know, Baltimore City is a community with established comprehensive adolescent pregnancy programs as well as special programs within the school system and numerous public and private health and social services agencies. Even so, evidence suggests that on a city-wide basis, substantial numbers of adolescent mothers are not receiving needed services. What is not known is the extent to which pregnant and parenting adolescents are unaware of available resources, are reluctant or unable to use them, or when they do use them, fail to achieve the full expected benefits.

Our study addresses this issue by examining the availability, accessability, coorination and use of services for pregnant and parenting adolescents in Baltimore. (Slide 1) The major objectives of the study are: to measure the scope and costs of existing resources, to identify barriers impeding access to needed services, and to identify the high risk sub-groups for whom services need to be provided. Where adolescent mothers are being reached, the study will identify factors associated with increased risk of not achieving expected benefits.

The study's theoretical framework is shown in Slide 2. This model is based upon that used by Aday and Anderson in their studies of access to medical care. It incorporates both delivery system and population characteristics as factors influencing utilization of services. The study is comprised of two distinct data collection efforts. The first is a survey of the medical, educational and social service programs and agencies within the City, and the second is a population-based survey of girls 17 or less who give birth in the City in 1983. While the resource survey focuses on two of the framework's major components, that is, policy and characteristics of the delivery system, the population-based survey furnishes information on the three remaining components, that is, characteristics of the population at risk, consumer satisfaction, and service use.

Today, I will begin by describing the study methods for first the resource survey and then the population-based survey. Following this, I will give a simple example of how the study data will be used, by sharing with you some of the information gathered thus far in our interviews with the adolescent mothers.

11. Resource Survey Methods

In a broad sense, the resources available to pregnant and parenting adolescents can be categorized as "institutional" and "individual". Institutional resources refers to the network of medical, educational and social service programs and policies. Individual resources are those available from the adolescent's family, friends and neighbors. While individual resources are examined in the population survey, the institutional network is the focus of the resource survey.

The scope of the resource survey is defined as all Baltimore City agencies and programs providing one or more of the services shown in Slide 3. For the most part, these are the services most essential or desirable for pregnant and parenting adolescents, as indicated by their designation as "core" and "supplemental" services in the Title VI grant program.

Identification of resources began with a review of nine existing service directories, such as that published by the Health and Welfare Council. From these, the initial resource list was developed and distributed to Hopkins Adolescent Pregnancy staff for review and modification. Over the past two months, our survey coordinator has telephoned or met with representatives of virtually all of the 250 identified resources. Her objectives were to further refine the resource list, to inform sites of our study and their role in it, and to identify within each site the individual who is best able to complete the survey questionnaire.

The survey itself begins this month and is expected to continue through January. Each resource is asked to complete a six page questionnaire that covers the areas displayed in Slide 4. When the survey is completed, we hope to be able to describe the existing service system in detail, particularly the criteria that define who is eligible to receive services at each type of program, and the ways in which resources coordinate their services through formal referral arrangements.

111. Population-Based Survey Methods

The population -based survey began in March of this year. The study population is defined as all Baltimore City residents age 17 or less who gave birth in 1983. From this group, approximately one-third, or 450 adolescents, is selected randomly for interview. The study sample is stratified on the mother's age at delivery, race and number of living children, since these characteristics may well influence her knowledge of and access to needed services. To assure sufficient numbers in each stratum, disproportional sampling is used. For example, using 1981 City birth statistics, we project that approximately 50 white adolescents will give birth at age 15 or less in 1983. From this group, we are selecting 100%, or all 50 girls. On the other hand, we estimate that slightly over 400 17 year old black adolescents with no other living children will give birth this year. From these, we are randomly selecting 15% for a sample size of 60.

During the course of the study, each selected adolescent mother is interviewed twice--first at about 3 months postpartum and again at 15 months postpartum. In the first interview, we solicit information on characteristics of the adolescent that may influence her access to resources, including household composition, socio-economic status, previous resource use, perceived need for specific services and availability of assistance from family and friends. In addition, we question the adolescent regarding the types of services she has received, the sites at which they were obtained, her reasons for selecting each site, and her satisfaction with the services received. For each service not received, the adolescent is asked whether she wanted the service, whether and where she tried to get it, and the reasons she failed to get it. Finally, the interview gathers information on outcomes associated with service receipt or nonreceipt, including complications during pregnancy and at delivery, use of contraceptives, educational goals and achievement, and indicators of financial independence.

The 15-month postpartum interview parallels the first in that it focuses on the types of services desired, sought and obtained in the prior year, their source and the reasons for selecting each source. In addition, we will examine the adolescent's sexual activity and use of contraceptives, her educational and vocational experience, economic status, and social mobility. Finally, the interview will be used to assess the child's development and medical history, as well as the role of the child's father over the past year.

IV. Results

Now I would like to share with you a very preliminary look at some of what we have learned from a portion of the girls interviewed to date, specifically, black adolescents who gave birth in January through April of this year, and have no other living children. In total, 82 adolescents in this broad category were selected for inclusion in the study. Of these, 73, or 89% were interviewed. Comparison of respondents and non-respondents with regard to demographic and medical variables contained in birth certificates revealed no significant differences between the two groups. (Slide 5) For the most part, the girls interviewed are very much like those described in the Sunpaper's recent series on the breakdown of the black family in the city. As shown in the slide, the girls tend to come from highly mobile, large households headed by a female. Half of the respondents had moved at least once in the past five years, and one-fifth had moved one or more times since they learned they were pregnant. One-fifth of the households have eight or more members. Nearly 80% of the girls live in households headed by a female. The cyclical nature of adolescent pregnancy is demonstrated by the age of the respondent's mother at the time of her first birth. In three-fourths of our cases, the maternal grandmother was a teenager when she had her first child; in half of the cases, she, like her daughter, was 17 years of age or younger. The economic status of the respondents' households is reflected in the employment status of their members. In nearly half of the households, no one is employed, and in 57.5%, no one is employed full-time. Over four-fifths of the households are dependent on public assistance.

Because today's conference has centered on comprehensive adolescent programs, it seems appropriate to examine the prenatal course of those enrolled in such a program versus those who received their prenatal care from other sites. My objective is not to present definitive evidence that enrollment in a comprehensive adolescent pregnancy program leads to better outcomes for the young mother and her child, but rather to give you a simple illustration of how study data can be used to describe the ways in which our city's parenting adolescents use the system of resources available, and the consequences of different patterns of resource use. Since adolescent pregnancy programs strive to identify and meet their clients special educational and social service needs, we will look not only at the medical aspects of pregnancy, but also at the respondents' ability to obtain needed food while pregnant, her parenting skills, academic course, and method of child care.

In this sample of 73, two 14 year old respondents received no prenatal care. In both instances, the respondent denied being aware that she was pregnant until shortly before delivery. Of the remaining 71 cases, 24 were enrolled in either the Hopkins Adolescent Pregnancy Program, or that offered at the University of Maryland. The remaining 47 cases received their prenatal care at other sites.

Slide 6 displays the respondents' household characteristics by site of prenatal care. The two groups are remarkably similar in all but two respects. A larger proportion of adolescent pregnancy program enrollees come from households headed by a female and dependent upon assistance from the Department of Social Services. I should note also that adolescent program enrollees are slightly younger at delivery than those who received their care elsewhere, the mean ages of the two groups being 15.2 and 15.8 years, respectively. All of these differences would place the adolescent program enrollees at higher risk of the adverse consequences of early childbearing.

Slide 7 displays our findings with regard to selected aspects of the adolescent's prenatal course. Girls enrolled in an adolescent pregnancy program tended to begin their prenatal care earlier. Only one-eighth of those in an adolescent program began prenatal care in their third trimester, as opposed to over one quarter of those receiving care from other sites. As might be expected, those in adolescent programs averaged slightly more prenatal visits. While similar rates of high blood pressure, pre-eclampsia and eclampsia were found in the two groups, nearly twice as many girls receiving prenatal care outside an adolescent program reported being told they had anemia than did those in an adolescent program. Similarly, the rate of hospitalization during pregnancy was over twice as high for girls receiving care outside an adolescent program, their rate for caesarian section was three times that of adolescent program enrollees, and their children were more likely to be of low birthweight. None of the children born to adolescent program enrollees required intensive care services at birth; 3, or 6.5% of those born to girls in the other group did require such services. The different rates for caesarian section are not reflected in the mothers' and childrens' length of hospitalization at birth, which are similar for the two groups.

(Slide 8) The difference in rates for anemia during pregnancy may well be associated with the respondents' ability to obtain needed food. As shown in the slide, only 4.2% of the adolescent program enrollees reported having difficulty getting the food they needed while pregnant. Nearly 15% of the girls receicing prenatal care from other sites had difficulty obtaining food; 8.5% had such difficulty although they were WIC recipients, and an additional 6.4% were not enrolled in WIC.

A major objective of adolescent programs is to provide instruction in parenting skills. Slide 9 displays the proportion of girls in each group who reported they did receive instructions as part of their prenatal care. In every instance, girls receiving prenatal care outside an adolescent program were less likely than their adolescent program counterparts to have received instruction. The difference is most striking with regard to instruction on the importance of interacting with an infant. Here 79.2% of adolescent program enrollees recalled receiving such instruction, as opposed to only 55.3% of those enrolled in other programs.

Of course, one of the major consequences of pregnancy is its impact on the adolescent's academic training. (Slide 10) Nearly all of the girls in this sample were attending school when they learned they were pregnant. Of those enrolled in an adolescent program, only 8.7% dropped out of school because of their pregnancy. Among those receiving prenatal care at other sites, the dropout rate due to pregnancy was 22.0%. Adolescent program enrollees were slightly more likely to transfer to the Paquin school. At the time of the interview, nearly all adolescent program enrollees had either completed their planned schooling or were attending school. In the other group, 85.4% were in school or had completed their schooling.

Often, the adolescent mother feels unable to pursue educational and vocational pursuits because she must care for her child. (Slide 11) Of the girls we interviewed, marked differences in child care arrangements were evident by site of prenatal care. Among adolescent program enrollees, one quarter reported they took care of their child at home at the time of the interview. In the comparison group, over two-fifths were caring for their child at home. Adolescent program enrollment was associated with greater use of the State's day care home services.

When asked about their plans for day care, less than 5% of program enrollees, versus nearly one-fifth of those receiving care at other sites, stated they would prefer to care for their children themselves one year from now. Adolescent program enrollees were twice as likely to cite a day care home as the preferred method of day care at that time.

In summary, the preliminary findings presented here illustrate how a difference in resource use for prenatal care is reflected not only in medical outcomes, but also in the adolescent's use of other resources, such as the WIC program, the Paquin School, and licensed day care homes, While I must underscore that these are only preliminary findings, I hope you have gained some understanding of the objectives, methods and potential value of this study of how adolescents use the system of resources available in Baltimore City, and the health, educational and social consequences of different patterns of resource use.

Slide 1

STUDY OBJECTIVES

To measure the scope and costs of existing resources for pregnant and parenting adolescents

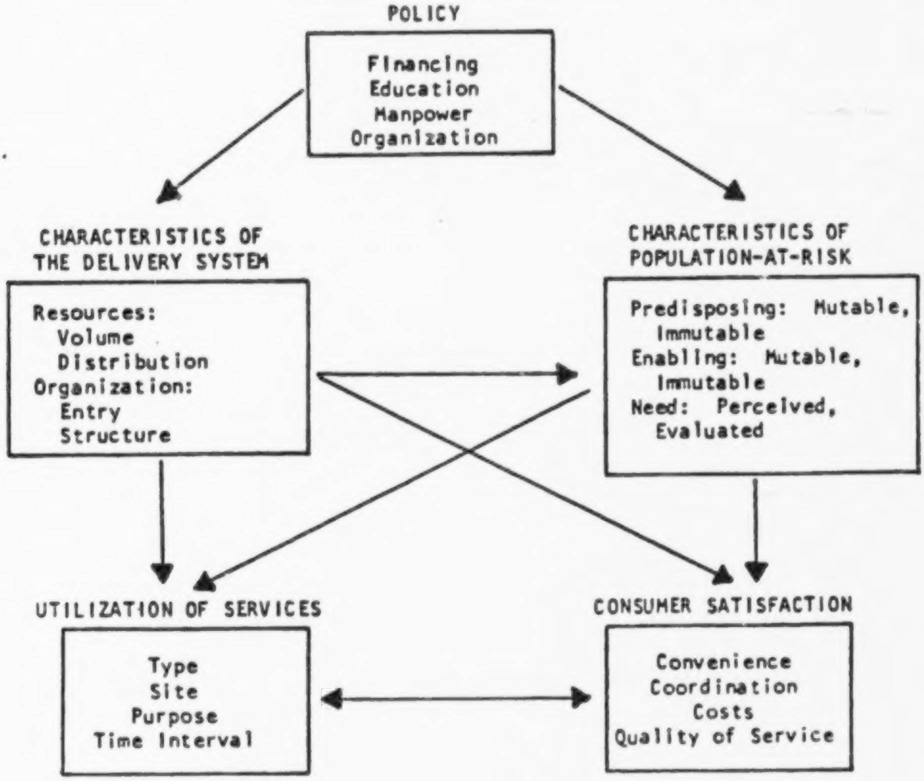
To identify barriers impeding access to needed services

To identify the high risk sub-groups for whom services need to be provided

To identify factors associated with increased risk of not achieving expected benefits of services

Slide 2

FRAMEWORK FOR THE STUDY OF ACCESS TO MEDICAL, EDUCATIONAL AND SOCIAL SERVICES



POLICY

Financing
Education
Manpower
Organization

CHARACTERISTICS OF THE DELIVERY SYSTEM

Resources:
  Volume
  Distribution
Organization:
  Entry
  Structure

CHARACTERISTICS OF POPULATION-AT-RISK

Predisposing: Mutable, Immutable
Enabling: Mutable, Immutable
Need: Perceived, Evaluated

UTILIZATION OF SERVICES

Type
Site
Purpose
Time Interval

CONSUMER SATISFACTION

Convenience
Coordination
Costs
Quality of Service

Slide 3

SERVICES FOR PREGNANT AND PARENTING ADOLESCENTS

- Family Planning - Contraceptives
- Sex Education
- Pregnancy Testing
- Pregnancy Option Counseling
- Adoption Placement
- Abortion
- Prenatal Care
- Nutrition Counseling
- Venereal Disease Screening and Treatment
- Residential/Maternity Home
- Parenting Skills Education
- Mental Health Counseling for the Adolescent and Family Members
- Pediatric Care
- Child Day Care
- Academic Education and Vocational Training
- Employment Counseling
- Financial Assistance, Including Food and Housing

Slide 4

ORGANIZATIONAL CHARACTERISTICS EXAMINED IN THE RESOURCE SURVEY

Sponsorship and Funding Sources

Goals and Objectives

Target Population and Population Served

Personnel --- Types, Numbers, Qualifications

Types of Services Offered and Quantity of Each

Linkages and Referral Arrangements with Other Resources

Access Characteristics:

Location, Hours of Operation, Transportation,
Accomodations for Children Accompanying Parents,
Telephone Access, Appointment System
Eligibility Criteria, Cost of Services to Recipients

RESPONDENT HOUSEHOLD CHARACTERISTICS

(N = 73)

2+ Residences in the Past Five Years	52.1%
2+ Residences Since Learned Pregnant	21.9%
Eight or More Household Members	20.6%
Female Head of Household	80.8%
Respondent's Mother First Gave Birth at Age 17 or Younger	49.2%
No Household Members Employed	47.9%
No Household Members Employed Full Time	57.5%
Receiving Assistance from DSS	84.9%

RESPONDENT HOUSEHOLD CHARACTERISTICS BY SOURCE OF PRENATAL CARE

	Adolescent Pregnancy Program (n = 24)	Other Source (n = 47)
2+ Residences in Past Five Years	50.0%	55.3%
2+ Residences Since Learned Pregnant	25.0%	21.3%
Eight or More Household Members	20.8%	19.1%
Female Head of Household	91.7%	70.2%
Respondent's Mother First Gave Birth at Age 17 or Younger	45.0%	51.3%
No Household Members Employed	50.0%	46.8%
No Household Members Employed Full Time	58.3%	57.4%
Receiving Assistance from DSS	91.7%	80.9%

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CHARACTERISTICS OF PREGNANCY AND DELIVERY BY SITE OF PRENATAL CARE

	Adolescent Pregnancy Program (n = 24)	Other Source (n = 47)
Trimester When Prenatal Care Began		
First	33.3%	34.8%
Second	54.2%	39.1%
Third	12.5%	26.1% *
Mean Number of Prenatal Visits	9.8 visits	8.3 visits
Complications of Pregnancy		
Anemia	12.5%	25.5%
Hypertension	20.8%	19.6%
Pre-eclampsia or Eclampsia	4.2%	4.5%
Mother Admitted to Hospital During Pregnancy	8.3%	19.6% *
Caesarian Section	4.2%	13.0% *
Birthweight Less Than 2500 Grams	4.2%	14.9% *
Child Admitted to Intensive Care Unit Following Birth	0.0%	6.5% *
Mean Length of Stay of Mother at Delivery	3.9 days	3.6 days
Mean Length of Stay of Infant at Birth	3.6 days	4.2 days *

*Indicate characteristics which are likely to materially increase costs.

RESPONDENTS' ABILITY TO OBTAIN NEEDED FOOD WHILE PREGNANT, BY SITE OF PRENATAL CARE

	Adolescent Pregnancy Program (n = 24)	Other Source (n = 47)
Had Difficulty Obtaining Needed Food	4.2%	14.9%
On WIC	4.2%	8.5%
Not on WIC	0.0%	6.4%
Always Able to Obtain Needed Food	95.8%	85.1%
On WIC	87.5%	53.2%
Not on WIC	8.3%	31.9%

PROPORTION OF RESPONDENTS RECEIVING PARENTING SKILLS INSTRUCTION AS PART OF PRENATAL CARE

	Adolescent Pregnancy Program (n = 24)	Other Source (n = 47)
How to dress baby	66.7%	53.2%
How to tell if baby is sick	70.8%	63.8%
How to take baby's temperature	70.8%	63.8%
Importance of holding, touching and talking to baby	79.2%	55.3%
How to make the house safe for baby	66.7%	57.4%
How and what to feed baby	83.3%	70.2%
Breast feeding	87.5%	76.6%

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ACADEMIC COURSE OF RESPONDENTS ENROLLED IN SCHOOL WHEN PREGNANCY DIAGNOSED, BY SITE OF PRENATAL CARE

	Adolescent Pregnancy Program (n = 23)	Other Source (n = 41)
Dropped out of school because of Pregnancy	8.7%	22.0%
Transferred to Laurence G. Paquin Junior/Senior High School	56.5%	48.8%
Attending school or completed Planned schooling at time of interview	95.6%	85.4%

Slide 11

CURRENT AND PLANNED CHILD CARE ARRANGEMENTS BY SITE OF PRENATAL CARE

	Adolescent Pregnancy Program (n = 24)	Other Source (n = 47)
Primary Caregiver at Time of Interview		
Respondent, at home	25.0%	42.6%
Respondent, at school	4.2%	0.0%
Relative	54.2%	48.9%
Day Care Home	16.7%	8.5%
Preferred Method of Child Care When Child Is One Year Old		
Respondent, at home	4.2%	19.2%
Relative	62.5%	66.0%
Day Care Home or Center	25.0%	12.8%
Uncertain	8.3%	2.1%

The Johns Hopkins Hospital

Children and Youth Program
Janet B. Hardy, M.D.C.M., Director

20 August 1984

Senator Jeremiah Denton
United States Senate
Room 440 Senate Hart Office Building
2nd and Constitution Avenue, N.E.
Washington, D.C. 20510

Dear Senator Denton:

I am delighted to know that your AFL bill, S.2616, was passed by the committee and the Senate and is hopefully on its was to reauthorization. Your interest and persistence have made a major contribution, please keep pushing for programs to help in this important area. I was pleased to learn that adolescent family planning has been added as a specific target in recent legislation which increased the funding for the MCH Block grant. An increase in support for maternal and child health has been direly needed. Thank you for your support.

I was pleased to present testimony before the Subcommittee on Family and Human Services. I will do my best to answer your questions.

1. The statistics from the Junior High School are indeed alarming. They seem to be borne out by studies in other schools which include a more diverse population of students. I hope that the goals of the Adolescent Family Life Act can have a positive impact by getting parents and children talking. However, by themselves they are not enough. Services, particularly contraceptive services are also required and these need to be easily accessible and affordable, free if need be, though I am convinced that the payment of even 50¢ or $1.00 for supplies helps to ensure compliance.

We are about to start home visits to parents in our inner-city area. These will be parents of children in grades 5, 6 and 7. The purpose is to provide preventive health education, including pregnancy and sexually transmitted disease prevention, and to encourage parents to talk with their children about these matters. We will also attempt to get parents to enroll their children for care in our Preventive Health Center.

In prior studies, we have demonstrated the abysmal ignorance about reproduction and contraception among the parents of 7th graders and their belief that contraceptives were not very effective. We also found that 94% of these parents supported sex education in the schools.

600 North Wolfe Street, Baltimore, Maryland 21205 (301) 955-2976

Frankly, my view is that good sex education in the schools is sorely needed. This education should not be limited to anatomy and physiology but should be broad enough to encourage responsibility, restraint, abstinence and sound decision-making.

I am attaching to this letter a copy of a paper by Frank Furstenberg, Jr., and co-workers. This paper, which is hot off the press, suggests that family communication does not account for very much in achieving prevention.

My personal opinion is that in dealing with preteens and adolescents, it is important to stress values and responsibility and abstinence but also to be practical (i.e. make contraceptives available) in one's approach to pregnancy prevention. My practicality also requires confidential services where these are really needed.

2. We have a research project funded by the Office of Adolescent Family Life in which we are examining the effect of resource use on pregnancy and longer term outcome for mother and infant. It appears that those mothers who receive care in comprehensive programs are linked into a network of needed services, such as WIC, special schooling and the like. Those mothers who deliver at community hospitals are much less likely to receive such services and do much less well, i.e. they have a higher frequency of low birthweight babies, more hospital admissions, hospital days, etc.

In my view, the most effective and economical way of handling the problem would be through use of regional centers where pregnant girls could be enrolled in comprehensive pregnancy and follow-up services. The services needed are expensive and cannot economically be provided in community hospitals which deliver only a small number of adolescents in any given year. Schools should be alerted to refer pregnant girls to comprehensive centers, similarly welfare agencies.

3. Actually, our data indicated an approximately $900 saving in medical care costs during the pregnancy and two years of follow-up. The $1,440 mentioned was from a more broadly based study which also included welfare utilization, at a very conservative level (1979 dollars). Current savings should undoubtedly be larger. Clearly, also special educational costs would be an issue, both for the mother in terms of grades repeated because of loss of time from school and ultimately for those children who do not do well because of low birthweight, neurological damage, mental retardation and social deprivation.

4. I am not aware of any data pertaining to savings due to averted costs for repeat pregnancy. Intuitively, they should be significant.

Comprehensive pregnancy care and follow-up programs are cost-effective and well worthwhile. Preventive services should be even better. However, until society finds some way of improving the educational and occupational opportunities for poor teenagers, the problems of pregnancy and VD will remain with us. Longer school hours, more relevant educational content, required athletics and sports participation and the possibility of part-time work at an entry level salary (below the minimum wage) would all help. These things all existed years ago when I went to school. Unsupervised, unoccupied stretches of time are dangerous for preteens and adolescents. What can we do about it? It is a complex and mammoth problem.

Sincerely,

Janet B. Hardy

Janet B. Hardy, M.D.C.M.
Professor of Pediatrics
Director, Johns Hopkins Children
and Youth Program

JBH/nm

Attachment

Family Communication and Teenagers' Contraceptive Use

From:
Family Planning Perspectives
Vol. 16, No. 4, July/Aug. 1984

By Frank F. Furstenberg, Jr., Roberta Herceg-Baron, Judy Shea and David Webb

Teens who communicated little with their mothers were as likely to use effective birth control as were those who communicated well. According to the authors, "the findings do not indicate that family communication counts for very much."

Summary

Improving communication about sex and birth control between parents and their children has often been cited as a means to encourage young people to use contraceptives more effectively. In an attempt to test this hypothesis, we interviewed 290 adolescents at family planning clinics in southeastern Pennsylvania three times in the course of 15 months about their communication with their families and their use of contraceptives.

At the time of their first clinic visit, two-fifths of the teenagers said that their mothers knew that they had gone to the clinic; this proportion rose to almost three-fifths six months later and to about three-quarters at the end of 15 months. However, the proportion of teenagers who said that they had discussed sex or birth control with their mothers remained almost the same; the proportion who said that they would never discuss such topics with their mothers also remained fairly constant. The teenagers whose mothers knew of their clinic attendance at the time of their first visit were no more likely to have had extensive conversations with their mothers about sex or contraception than were the teenagers whose mothers found out afterwards.

Among a subsample of the mothers of these young women, fewer than one-third said that they had ever discussed their daughters' sexual activity with them. There was only a modest level of correspondence between the mothers' responses and their daughters' replies; for the most part, the mothers thought that they were much more communicative about sex and birth control than their daughters perceived them to be. Although there were some indications that there was greater communication about sex among the teenagers who were more effective users of contraceptives, the better communication was apparently a consequence of effective contraceptive use rather than a cause of it: Teenagers who spoke little with their mothers about sex or birth control were no more or less likely to be effective users than were those who communicated well with their mothers. In all, family communication about these topics appeared to count for very little with regard to levels of contraceptive use among sexually active teenagers.

Introduction

Over the past decade, the proportion of sexually active adolescents has increased dramatically, and this pattern has created a climate of concern in American society.[1] The gap between the onset of intercourse and the timing of marriage has widened considerably because young people are initiating sexual relations much earlier than they ever have and are marrying a good deal later than has been the custom in recent generations. Accordingly, the risk of premarital pregnancy has risen sharply, resulting in some increase in abortion and elevated levels of out-of-wedlock childbearing among teenagers.[2]

During the 1950s, early marriage, adoption and illegal abortion masked the number of premarital conceptions among adolescents. Today, young women who become pregnant before marriage are not as likely to resort to any of these "solutions." Consequently, teenage sexual activity and pregnancy are far more visible than they were a generation ago, and are made even more so by the availability of national health statistics and data from social surveys. What was once discreetly concealed is now openly revealed.

The heightened visibility of teenage sexuality, pregnancy and childbearing generated much interest in preventive policies and services in the 1970s. After a brief but spirited debate, federal funding was provided to make family planning services available to sexually active adolescents. This effort seems to have had some qualified success in slowing the rate of growth in teenage pregnancies; 1.5 million teenagers obtained birth control services from federally funded programs in 1979, averting about 367,000 unplanned pregnancies.[3] However, research has shown that adolescents have a great deal of difficulty in using birth control consistently.[4]

One significant barrier to effective contraceptive use by teenagers is their fear of being discovered by their family. Most sexually active girls believe, probably with good reason, that their parents would strongly disapprove of their behavior if they knew. Several studies have reported that teenagers use birth control less often and less effectively when their parents do not know that they are having sexual relations and would disapprove if they found out.[5] Consequently, some experts have suggested that one way to increase contraceptive practice among teenagers would be to break down the wall of silence separating adolescents from their parents.[6] If parents were better informed, it is argued, they might accept (albeit reluctantly) the need for contraceptive services and therefore

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might more openly endorse the use of a method. In turn, teenagers might feel more free to practice contraception once the fear of being found out was allayed.

In the past several years, a number of proposals have been advanced for promoting greater communication between adolescents and their parents. These have ranged from voluntary programs of public education and family counseling to mandatory parental consent or notification. The controversy over the DHHS's proposed "squeal rule," enforcement of which has been enjoined by the courts, exposed a number of practical obstacles to mandated notification of parents. Besides showing the programmatic considerations involved with implementing a notification procedure, the debate over the squeal rule revealed that empirical research on the relationship between family communication and contraceptive practic[illegible]remely thin. There is little information on the process of sexual socialization within the family, and even less that addresses directly how teenagers' sexual practices are affected by their parents' attitudes and actions.

The idea of involving parents more directly in family planning service programs in order to build support for contraceptive practice has aroused considerable controversy. Even most proponents are aware of the practical problems involved. It is well documented that adolescents highly value the confidentiality currently offered by family planning clinics.[7] It is believed that mandatory measures such as parental notification might deter a large proportion of adolescent clients from seeking family planning services.[8]

Communication and Method Use

Existing studies of sexual socialization in the family do not provide a clear or consistent picture of how parents' attitudes and sanctions shape adolescents' sexual practices.[9] Many have been plagued by methodological problems, such as a reckless tendency to generalize from research on special samples. For example, findings from college samples cannot be extended to more youthful populations or to teenagers from different social strata. In addition, researchers often infer parental influence from poorly measured or poorly conceived indicators. Data collected only from adolescents asked to supply information on their parents' views cannot be used as a proxy for the actual views of parents; previous research has definitively demonstrated that teenagers are frequently mistaken about their parents' views (and vice versa).[10] Finally, most of the current research consists of cross-sectional studies that do not examine the issue of causality and leave open the question of how associations are to be explained. For example, if parental communication is positively related to teenagers' contraceptive use, it is not at all clear whether the teenagers use a method at the urging of their parents or if they are merely more willing to communicate with their parents once they are committed to practicing contraception.

Two excellent reviews have sifted the evidence in an effort to derive lessons relevant to public policy. Greer Litton Fox carefully weighed findings from previous studies of the family's role in shaping adolescent sexual behavior and reached the following conclusions: There is very little direct communication from parents to children; what little there is generally occurs between mothers and daughters; and communication may have a marked effect on behavior, forestalling the initiation of sexual activity and promoting more effective contraceptive practice.[11] Fox observes, however, that in the absence of longitudinal studies, researchers have yet to demonstrate a causal connection between parental communication and adolescent sexual behavior.

In another review, Susan Philliber related her own research to that of others and discovered that communication about sex and birth control, even between mothers and daughters, is often accompanied by strain and uncertainty.[12] Although parents and children both reported conversations about contraceptive use, the conversations were generally oblique; sometimes mothers and daughters did not even agree on whether such discussions had taken place. Philliber's results agree with those of an earlier study showing that a high proportion of adolescents and their mothers did not agree when asked whether birth control had been discussed.[13] Her findings also reinforce the results of a recent study showing that when conversations about contraception occur between mothers and daughters, they are much more frequently perceived as uncomfortable by the daughters than by the mothers.[14] The researchers did find, nonetheless, that frequent conversation was related to the daughter's receptivity to birth control use.

The study described in this article resulted from an experimental program begun by several federally funded family planning agencies affiliated with the Family Planning Council of Southeastern Pennsylvania. The program was designed to assist teenage clients to talk more openly with family members about their sexual activity and contraceptive use. The larger research project tested the hypothesis that through a planned intervention, it would be possible to increase the level of communication between sexually active adolescents and their families, and furthermore, that if a more open climate of communication were produced, adolescents would receive and perceive more support for contraceptive practice.

Methodology

The Kinship Study, as the project came to be known, was funded in 1979 by a grant from the Office of Family Planning. Adolescent participants were drawn from six federally funded family planning agencies operating nine separate clinic sites. The agencies included three Planned Parenthood affiliates, two hospital programs and one neighborhood health center. Each had a large proportion of teenage clients and expressed its willingness to cooperate in the research by expanding its programs for parental involvement. These clinics served a racially diverse mix of adolescents from urban, suburban and semirural areas, as well as from a variety of economic strata.

Between January 1980 and September 1981, new teenage family planning patients at the nine clinics were invited to participate in the study; nearly 90 percent agreed, yielding a sample of 417 adolescents. They were assigned at random to one of two experimental groups or to a control group. Twenty-four percent were invited to receive family-oriented counseling provided by specially trained counselors. (This program has been described in some detail previously.[15]) Another 18 percent were given periodic support for contraceptive use by one of the members of the research team (over the telephone rather than in person) at about the same time that the family counseling took place. The remaining 58 percent received routine clinic services and served as controls. By design, most of these adolescents were given an initial interview and a six-month and a 15-month follow-up interview. A small proportion of the adolescents in the control group were contacted only after 15 months, when the impact of the whole program was being assessed. This article concentrates on an analysis of some 290 teenagers who participated in all three interviews.

As can be seen in Table 1, the sample was evenly divided between white and black teenagers. Almost all of the study participants were enrolled in school when they entered the study (not shown). Thirty-eight percent were 17 years old at the beginning of the study, 31 percent were 16 and 30 percent were 15 or younger. Nearly all of the respondents were making their first visit to a family planning clinic (not shown). However, 86 percent had been sexually active before they came to the clinic, and 38 percent had initiated intercourse at least one year before their clinic visit. About 21 percent had been pregnant at least once, and 10 percent were already mothers at the beginning of the study. All but four of the young women were single.

Sixty-one percent of the participants were living with both natural parents at the time of the initial clinic visit, and most of the others were living with one biological parent. (All but nine percent were residing with their biological mothers.) Considering the education only of the best-educated parent, we found that 16 percent of the parents had not graduated from high school, 52 percent had completed high school but had gone no further, and the remaining 32 percent had had some college or postsecondary education.

It is important to keep in mind that this sample was limited to adolescents who sought services from a federally funded family planning clinic. Only a minority of all sexually active adolescents obtain birth control from family planning clinics.[16] Thus, our study does not reflect the experiences of adolescents who obtain contraceptives from private physicians, those who rely on nonprescription methods obtained from a pharmacy or those who do not use any method at all. Moreover, our sample was not selected to ensure that it was representative even of the geographic area from which it was drawn. In comparison to the larger population of 13,000 teenage clients served by agencies in the Family Planning Council of Southeastern Pennsylvania, white teens were slightly overrepresented, although the age distributions, pregnancy histories and parenting experiences of the sample closely resembled those of all the adolescent clients.

Eighty-eight percent of the teenagers who agreed to participate in the study and who completed an initial interview were interviewed again at six months, and 85 percent completed a second follow-up, an average of 15 months after the initial visit. Only seven percent refused to participate in the final interview, and another eight percent could not be located. Dropouts were more likely to be younger teens and to be black. We suspect that those who dropped out were less likely to have been continuous contraceptive users and probably were also somewhat less likely to have had high levels of communication with their families. Consequently, our findings may slightly inflate the proportion of continuous birth control users and overstate the amount of communication in the family. Even so, because the loss to follow-up was so small, the distortion in our results cannot be very substantial.

Adolescents were asked how much time they had spent discussing sexual matters with their families, to whom they had spoken, how comfortable they had felt and what had been disclosed or discovered about their use of clinic services. As the study proceeded, we realized that more qualitative information about the content of discussions was needed, so in the final interview we tried to capture more details about the context in which the teenager disclosed her clinic visit.

Table 1. Percentage distribution of teenage family planning clinic patients who participated in all three interviews, by selected characteristics at the time of the initial interview

Characteristic	%
Race (N=287)	
White	49.5
Black	50.5
Age (N=289)	
≤15	30.4
16	31.1
17	38.4
Timing of first intercourse (N=272)	
Never had intercourse	14.2
<1 year before clinic visit	48.2
≥1 year before clinic visit	37.6
No. of pregnancies (N=288)	
0	79.5
≥1, at least one carried to term	10.4
≥1, none carried to term	10.1
Marital status (N=289)	
Never married	98.6
Currently married	1.4
Guardian (N=289)	
Mother and father	60.9
Mother and stepfather	10.7
Mother only	19.0
Other	9.3
Years of parental education* (N=271)	
<12	15.9
12	52.0
>12	32.1
Total	100.0

*Based on parent with highest education

The interviews were by necessity brief (20–30 minutes each), so the information in our study does not overcome some of the limitations inherent in the collection of information concerning such a sensitive subject through surveys. However, we can supply more information than any previous longitudinal study on the changing patterns of sex-related communication among sexually active adolescents and their parents. A subsample of 95 adolescents gave us permission to invite their mothers to be interviewed; we asked the mothers a parallel set of questions designed to measure their perceptions of family sexual communication. These supplementary data help to overcome the bias inherent in reliance only on the reports of the adolescents themselves.

The following analysis expands on a preliminary report that described the changing patterns of family communication between the initial interview and the six-month follow-up.[17] The preliminary results showed that most adolescents said that there was at least one family member with whom they could discuss sex and birth control. The adolescent's confidante usually had been her mother, a sister, or occasionally both, but sexual matters had rarely been discussed with a male family member. The importance of communication with female siblings rose between the two interviews, but teenagers' reliance on their mothers for information or support remained constant. Although they had not been more likely to become sexual confidantes, more mothers had learned of the clinic visit by the time of the second interview. The analysis did not address how the mothers had found out about the clinic visit or how they had responded to the disclosure.

The most striking result of the preliminary analysis was that neither communication about sex and birth control nor mothers' knowledge of the clinic visit was strongly related to the use of contraceptives by teenagers. Adolescents who said at the six-month follow-up that they could communicate with their mothers were somewhat more likely to practice contraception consistently during the study period, but the direction of the causal link is unclear, especially since communication at the time of the initial interview was unrelated to subsequent birth control practice. A more plausible interpretation would be that adolescents who used contraceptives regularly were somewhat more willing to speak openly with their mothers about sex and birth control.

In the following analysis of data from the 15-month follow-up, we confine our attention to the teenagers' communication with their mothers or female guardians, reserving for later a discussion of patterns of communication with siblings. (Too few fathers had discussed sex or birth control with their daughters for them to be included in the analysis.)

Mother-Daughter Communication

Table 2 (page 166) shows teenagers' responses from each of the three interviews that indicate the extent of mother-daughter communication. At the time of the first visit, the majority of teenagers had had limited communication with their mothers about the initiation of intercourse and their decision to visit a family planning clinic, even though most teens in our study said that they had fairly good relationships with their mothers. Forty-six percent said that they would be more likely to discuss a personal problem with their mothers than with anyone else (not shown). However, they were clearly more reticent about sex. At the time of the initial interview, 18 percent had told their mothers that they had had intercourse, although 32 percent guessed that their mothers might know anyhow (not shown). This possibility seems likely, since 41 percent reported that their mothers had been aware of their visit to the family planning clinic. Thirty-nine percent indicated that they usually discussed sex and birth control with their mothers. Although 68 percent expected that their mothers would approve of their decision to visit a clinic, 23 percent believed that their mothers would not approve (not shown), and 22 percent said that they did not want their mothers to learn about their clinic visit. Only 10 percent had been informed about or directed to the clinic by their mothers.

Our impresson from the initial interview is that at the time of their first clinic visit, many teenagers were reluctant to confide in their mothers. They preferred not to talk directly to them about being sexually active, although some were willing to allow their mothers to find out indirectly. A sizable minority took considerable pains not to let their mothers know. These data are consistent with anecdotal information collected in the course of the fieldwork. Some of the teenagers who had not informed their parents of their clinic visits were still willing to have us contact them at home for the interviews, even though we warned them that their parents might thereby learn of their contact with the clinic. Others refused to allow us to call them at home and worked out other arrangements for completing the interviews.

We asked fewer questions about communication at the six-month follow-up. Nonetheless, it is clear that substantive communication with mothers did not change greatly after the initial clinic visit. About the same proportion as in the first interview replied that they were able to talk to their mothers about sexual matters and birth control. A similar proportion said in the second interview that they would never discuss these subjects with their mothers. On the other hand, by the time of the second interview, there had been a distinct rise in the proportion of teenagers who said that their mothers knew about the clinic visit.

Table 2 shows that the proportion of teenagers who said that their mothers knew about the clinic visit continued to rise; by the time of the 15-month follow-up, a substantial majority of the mothers—72 percent—had learned that their daughters obtained birth control services. This does not signify, however, that communication between the teens and their mothers had been enhanced. About the same proportion of teenagers said that they discussed sex and birth control with their mothers as did so in the earlier interviews, and roughly the same proportion as previously stated that they never talked about these topics with their mothers. The majority of respondents at both the initial and the concluding interviews revealed that they were more likely to talk to a friend or someone outside their family about birth control than they were to talk to one of their parents or siblings (not shown). The proportion of those who said that they would confide in a family member remained stable over the course of the study.

Table 2. Measures of mother's or female guardian's knowledge of teenager's sexual activity and birth control use, at initial interview, six-month follow-up and 15-month follow-up

Parental involvement measure	Initial interview (%)	Six-month follow-up (%)	15-month follow-up (%)
Mother knows of clinic visit (N=279)	41	58	72
Teen usually talks about sex and birth control with mother (N=282)	39	37	38
Teen never talks about sex or birth control with mother (N=282)	15	17	16
Teen told mother that she was having or planning to have sexual intercourse (N=282)	18	na	na
Teen does not want her mother to know about her clinic visit (N=282)	22	na	na
Teen learned of clinic from mother (N=282)	10	na	na
Teen talked about sex and birth control with mother in last 4 weeks (N=274)	na	25	na
Use of birth control (N=278):			
Mother doesn't know	na	na	31
She knows, teen is uncomfortable	na	na	39
She knows, teen is comfortable	na	na	30
Compared with teen's female friends, she and her mother talk about birth control (N=271):			
Less often	na	na	37
About the same	na	na	27
More often	na	na	37

Note: na=question not asked.

The adolescents whose mothers knew that they were using contraceptives were asked how comfortable they had felt about sharing that information. Fifty-six percent said that they had felt somewhat or very uncomfortable about talking to their mothers about contraceptive use. Twenty-eight percent said that they had been somewhat comfortable, and only 16 percent reported that they had felt very comfortable in talking with their mothers about birth control (not shown). These adolescents were also asked an open-ended question concerning how their mothers had learned that they were practicing contraception. Thirty-eight percent of them reported that they had volunteered the information. One respondent replied, "I told her about the clinic visit a couple of weeks before. I just felt she should know. She approved. She thought I should go to the clinic." Twenty percent of the respondents said that their mothers had encouraged them to get birth control, and nine percent of them had been accompanied to the clinic by their mothers: "She took me up there. . . . She thought it was a good idea for me to go because the boy I was going with—he got one girl pregnant."

In another 24 percent of the cases, the teenagers' mothers had discovered contraceptives around the house, had been told by someone else or had learned through some other indirect means. Many adolescents reported that such a discovery had led to a direct inquiry from their mothers, sometimes in anger, but sometimes with relief. It was not unusual for the teens to report that their mothers had had mixed emotions: "I write poetry and I had a notebook sitting on the porch. It was my diary and she read it. She was mad that I [didn't] confront her with it, but she was happy [that] I was getting protection."

Of the mothers who knew that their daughters were using contraceptives, 56 percent either had known before the teenagers made their clinic visit or had found out at about the time of the first visit (not shown). Still, a substantial proportion of mothers had been informed only at some point after the six-month interview. Although we cannot say for certain, it does not appear from the comments in the open-ended interviews that the young women who had revealed their contraceptive use early had had any more extensive discussions with their mothers than those whose mothers had learned later. Judging from the replies, most adolescents who had told about their contraceptive use, whether willingly or unwillingly, earlier or later, had received relatively little feedback from their mothers. Few teenagers said that they had had lengthy conversations with or had received much reinforcement from their mothers, although about four out of five of those who talked about their mothers' responses thought that their mothers ultimately had approved of the clinic visit.

Collaborative information from a small number of mothers seems to bear out the teenager's perceptions about their mothers' support for use of birth control. The mothers generally supported contraceptive use if their daughters were sexually active. Still, there was little evidence of open and direct communication in the family, even though the subsample of mothers was biased by the inclusion of more mothers who openly communicated with their daughters. Most mothers believed that teens should learn about sex and birth control in the home; however, one-third of the mothers did not know that their daughters were sexually active, and fewer than one-third had actually discussed their children's sexual activity with them. Similarly, although two-thirds of the mothers knew that one of their children had attended a family planning clinic, only half had found out through direct communication. The rest had inferred that they used contraceptives from the teenagers' behavior and general conversations. Mothers said that they generally had learned of the clinic visit from their daughters after the fact, although one-third said that they had accompanied their daughters to the clinic on at least one occasion.

A comparison of the mother-daughter reports on sex-related communication showed only a modest level of correspondence. Mothers apparently believe that they are more communicative and comfortable about discussing sex and birth control than their daughters perceive them to be. Considering that the mothers in the study were interviewed only if their daughters agreed, the level of consensus was surprisingly low and the extent of communication was far from large.

What conditions within the family are associated with high or low levels of communication? In order to answer this question, we took measures from Table 2 and constructed three indexes of communication, pooling the various measures available from daughters at each interview time. The internal reliability measures of the indexes were quite acceptable,* and there was a strong association among the three indexes, suggesting that teens who reported high or low communication tended to be consistent in their accounts over time.

No demographic factors were strongly related to the extent of communication in the family. At the time of the initial interview, black teenagers were likely to report higher levels of communication than were whites, in large part because their mothers were more likely to have known of the clinic visit (59 percent compared with 21 percent). This difference in overall levels of communication diminished over time, as white mothers learned the news, although even at the final interview, black teenagers were much more likely than comparable whites to report that their mothers knew of the clinic visit (86 percent and 56 percent, respectively). The socioeconomic status of the parents seems to have had little effect on the amount of communication at any time during the study. Finally, we could discern little difference in the patterns of communication among older and younger adolescents. Moreover, teenagers who had ever been pregnant or who had initiated sex earlier were not any more likely to report higher levels of communication with their mothers.

Our inability to identify determinants of communication within the family parallels a finding reported by Fox,[18] who also was frustrated in a search for conditions promoting communication within the family. Part of the problem in our study may stem from the fact that we looked at a population of family planning clinic clients. One might expect that young women who seek out family planning services are better at communicating about sex and birth control than are sexually active teenagers who do not go to clinics. On the other hand, some research has suggested that high levels of family communication may lead to a delay in the initiation of sexual activity among college-age women.[19] This finding has not been corroborated for an adolescent population, however. If such a delay did occur among teenagers, it might limit the variability of communication in one sample, similarly hampering our ability to identify the influence of communication. Nevertheless, there is a fairly wide range in the measures that were used, so it is surprising not to be able to account for the patterns of communication.

Communication and Contraceptive Use

In a 1982 report, we noted little support for the expectation that adolescents who were less secretive about their sexual activity and use of birth control would use contraceptives more effectively.[20] Since the study was still underway at that point, we remarked that the findings might look different after a longer interval. Although communication at the time of the initial interview was not related to birth control practice at six months, there was a modest relationship between the amount of communication with mothers reported at six months and the adolescents' use of birth control during the six months after the first interview. This finding probably indicates that communication was a consequence rather than a cause of effective contraceptive practice, but a look at data from the second follow-up may provide a better test of our hypothesis.

Using the three indexes of mother-daughter communication about sex and birth control noted earlier, we examined the influence of communication at both the initial and the six-month follow-ups on subsequent contraceptive patterns, as well as the association between communication and birth control practice at the time of the final interview.

Birth control practice can be studied in a variety of ways, and a good deal of effort was put into designing the most sensitive and refined measure of contraceptive continuation. Elsewhere we have described the difficulty in creating a measure that reliably captures an adolescent's behavior.[21] When data from the six-month and 15-month follow-ups were contrasted, we discovered that adolescents frequently failed to recall periods of nonuse or provided inconsistent accounts of their contraceptive practice. When asked at different points in time, the same question produced varying responses. Different questions posed at the same time also yielded a certain amount of inconsistency.

As a result, our measure of steady birth control use is a stringent one. To be counted as a continuous user, a teenager always had to report that she used an effective method (the pill, IUD, diaphragm or condom) when she was sexually active. In order to establish this group, we excluded any adolescent who reported imperfect contraceptive use on *any* of the birth control questions included in the two follow-ups. Once discrepancies were resolved, a teenager was classified as a continuous user if she began using a reliable method within one month of her clinic visit and continued to use that method for the duration of the study. She was classified as an intermittent user if she used a reliable method for 80 percent of the months during the study period and for 80 percent of the time during those months in which she was sexually active. All sexually active adolescents not meeting these criteria were classified as ineffective users. We had complete histories for 289 adolescents; of these, three percent had never begun sexual activity and were excluded from the analysis. Of the teenagers who were sexually active, 43 percent had used a reliable method continuously with no lapses, 23 percent had used contraceptives intermittently,

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*The internal reliability measures, as determined by alpha factor analysis, ranged from 0.64 to 0.70.

Table 3. Percentage distribution of teenage clinic patients who ever used contraceptives, by contraceptive-use status (continuous, intermittent or ineffective) at each of three interviews, by various measures of parental knowledge of teens' sexual activity and birth control use

Measure	Initial interview				6-month follow-up				15-month follow-up				Total
	Continuous	Intermittent	Ineffective	N	Continuous	Intermittent	Ineffective	N	Continuous	Intermittent	Ineffective	N	
Mother knows of clinic visit													
Yes	38	26	36	110	44	23	34	158	44	23	34	194	100
No	46	22	32	164	41	24	35	116	39	23	39	78	100
Teen usually discusses sex and birth control with mother													
Yes	45	23	32	105	47	22	31	99	40	24	36	172	100
No	41	24	35	169	41	24	35	175	46	21	33	106	100
Teen never discussed sex or birth control with mother													
Yes	43	33	25	40	45	28	28	47	41	28	30	46	100
No	43	22	36	234	42	23	35	227	43	22	35	232	100

and the remaining 34 percent were classified as ineffective users.

In Table 3, the teenagers' patterns of contraceptive use are contrasted with their responses to three questions about the extent of their communication with their mothers. (Each question was asked in all three interviews.) In most cases, there appear to be slight differences in the levels of continuous contraceptive use according to the extent of parental communication. For example, the proportion of teenagers who were continuous users at the six-month and 15-month follow-ups is slightly higher among those whose mothers knew about their clinic visit than among those whose mothers did not know. However, other differences are in the opposite direction. For example, teenagers who said at the 15-month follow-up that they had not discussed sex or birth control with their mothers were slightly more likely to be continuous users than were those who had discussed these subjects. Overall, none of these differences are large, and none are statistically significant. This is also true of certain questions that were asked only once, such as whether the teenagers had told their mothers that they were sexually active and whether they wanted their mothers to know about their clinic visits. The overall pattern does not indicate a link between family communication and contraceptive use. Since the various measures are highly intercorrelated, we examined the association of the three indexes of communication with contraceptive use. Again, none of the indexes were significantly related to contraceptive use.

One additional test of the effect of family communication on contraceptive use was made. For the two questions concerning discussion of sex and birth control, we examined the contraceptive-use patterns of the teenagers who reported continuously high or continuously low levels of family communication, these were compared with use patterns of teens whose communication with their mothers had improved during the course of the study. (No adolescents reported worsened communications.) Although the differences were not large, teenagers who had improved communications with their mothers had higher levels of regular use than those who had not done so (49 percent and 40 percent, respectively). However, teenagers who had had little communication about sex with their mothers at both points in time were not significantly less likely to have used birth control effectively than were those who had communicated well with their mothers. Again, the findings do not indicate that family communication counts for very much. Furthermore, it seems more plausible that such communication follows, rather than precedes, contraceptive use.[22] For example, teenagers were just as likely to practice contraception effectively if communications with their mothers had improved between the first and second follow-up as they were if communication had improved between the initial interview and first follow-up. This suggests that teenagers who were using contraceptives regularly eventually divulged their secret, but they were just as likely to do it later as sooner; when they did, it did not seem to affect their use of contraceptives.

Data also were collected from 95 mothers. Although this subsample was distinctly biased toward inclusion of mothers with higher levels of communication with their teenagers, many of them had limited communication with their adolescent children. If communication matters, we might expect to find that mothers who felt freer to talk to their children and who reported knowing that their daughters had visited a clinic would have encouraged more effective contraceptive practice. However, no measure of the extent of communication between the mothers and their children was significantly related to the daughters' birth control use. Once again, we are led to conclude that communication between mothers and daughters does not significantly alter an adolescent's ability to use contraceptives effectively.

The level of communication might be less influential than the emotional tone of any conversations or the specific message conveyed by the mother. After all, not all mothers who talk with their children about sex and birth control do so in a style that supports or reinforces the use of birth control. The initial and first follow-up interviews included only one question in this area, asking adolescents who had confided in their parents whether or not their parents approved of their use of birth control or of their decision to attend the clinic. Neither measure was related to subsequent patterns of contraceptive use. In the final interview, the nature of communication was probed more deeply, through a retrospective, open-ended question on how the mother had learned of the clinic visit. This question was designed to determine the degree to which the respondent's mother had initiated the conversation and whether the teenager thought that her mother supported her visit to the clinic. Neither initiation nor support was related to contraceptive continuation.

Even if contraceptive use by the adolescent does not appear to have been affected by the amount or type of communication, the mother's influence may still be apparent in other ways. Since parents may be concerned about the health effects and safety of certain birth control methods, adolescents who have more open and active communication with their mothers might be more likely to return to the clinic for a checkup within the recommended time. Data on return visits were extracted from clinic records and were added to the data file, enabling us to examine the relationship between family communication and clinic continuation. We considered both the number of return visits and the timing of such visits. There was no significant association between mother-daughter communication or the mother's knowledge of the clinic visit (at either the initial interview or the six-month follow-up) and the pattern of clinic use. There was a significant relationship between the timeliness of the teenager's return visits and the mother's knowledge of clinic use at the time of the 15-month follow-up. However, evidence again indicates that communication was a consequence rather than a cause of clinic attendance. Adolescents who returned on time were often more likely to have shared the information with their parents, but teenagers who shared the information before or soon after visiting the clinic for the first time were not significantly more likely to return for a checkup.[23]

Discussion

A popular but untested belief among policymakers and some practitioners is that teenagers will be more likely to use birth control effectively if their parents, especially their mothers, know that they need such services and agree with their decision to visit a clinic. However, in this study, we found no support for the assumption that the mother's knowledge of the clinic visit enhances her teenage daughter's ability to use contraceptives effectively. It seems unlikely that a policy of notifying adolescents' parents about their clinic visits will produce any more positive results.

We also discovered that the mother's awareness of her daughter's clinic visit, though associated with greater communication in the family, frequently was associated with little or no discussion between the mother and her daughter. The proportion of adolescents who said that their mothers knew that they had obtained contraceptive services shot up from 41 to 72 percent during the course of the study, but the proportion who reported that they felt able to talk to their mothers about sex and birth control did not change at all. Clearly, in most families, the mother's knowledge that her daughter is using birth control did not stimulate more mother-daughter discussions about sexual behavior or contraceptive use.

In general, even when discussions do occur, they seem to contribute very little, if at all, to the adolescent's ability to practice contraception effectively. Using a variety of measures, we looked for evidence that communication with mothers influenced the teenagers' consistency of birth control use or the punctuality with which they returned to the family planning clinic, but we were repeatedly led to the conclusion that communication counts for very little.

Why this is so remains an intriguing question. On the basis of discussions we have had with parents of adolescents, we suspect that there are several different reasons why the influence of parents seems to be so slight. First, most parents do not want to get directly involved and, certainly, most teenagers are reluctant to encourage such involvement. Most parents would prefer that their teenagers defer sexual activity, but they seem resigned to the fact that their views are not likely to be the single determining factor. Recognizing that sexual activity is likely to take place, parents want to be sure that their daughters do not become pregnant. Consequently, many are relieved to discover that their children are getting contraceptive help. Beyond that, it seems that most are willing to respect the adolescent's privacy.

Parents acknowledge either directly or implicitly that their children are more likely to talk with their peers or with other adults about sexual relationships. Many more of the young women in our study shared information with their sisters than with their parents, even more of them consulted their girlfriends. Whether or not one believes that this pattern is desirable, the parents we talked with generally were realistic about how much influence they could exert.[24] As Fox has so perceptively observed, most parents shift from acting as protectors to serving as guides when their children enter adolescence.[25] They attempt to forestall sexual initiation, but when it occurs, they are forced to adopt a different strategy. At best, they can provide information and advice to their children, but they probably are incapable of regulating their children's behavior.

Does this mean that family planning agencies ought not to attempt to involve parents in their program? We continue to support the efforts of many programs to reach out to parents, particularly the parents of adolescent clients. Our discussions with parents reveal that many of them want and need the information that may better equip them to provide authoritative sexual guidance to their children. Some parents want to be able to communicate more easily with their teenagers, while others want to marshal as much information as they can to dissuade their children from engaging in intercourse, others want to know only enough to be able to direct their children to appropriate agencies for assistance. Clearly, one preventive approach with a single message will not satisfy the diverse needs of parents.

Family planning clinics have a special obligation to assist parents in general—and the parents of their adolescent clients in particular—who want to expand their educational and supportive roles. Family planning agencies have been designing and offering programs to direct more attention to parents and community education, but these efforts can only be part of a comprehensive strategy. One promising approach that has hardly been developed is the wider use of mass media, especially radio, television and home video cassettes. In the meantime, we hold out little hope for the effectiveness of efforts to mandate parental involvement. Admittedly, the study described in this article is not the final word, but the data provide compelling evidence that compulsory notification of parents whose teenage daughters enroll at family planning clinics is not likely to benefit the teenagers, at least in regard to their contraceptive use. It appears far wiser to try a flexible approach for involving parents in family planning agencies, by experimenting with and evaluating a number of family-oriented programs, than to mandate rigid and bureaucratic solutions that are untested and probably unworkable.

References

1. M. Zelnik and J. F. Kantner, "Sexual Activity, Contraceptive Use and Pregnancy Among Metropolitan-Area Teenagers: 1971–1979," *Family Planning Perspectives*, 12:230, 1980.

2. F. F. Furstenberg, Jr., R. Lincoln and J. Menken, *Teenage Sexuality, Pregnancy and Childbearing*, University of Pennsylvania Press, Philadelphia, 1981; and M. Zelnik, J. F. Kantner and K. Ford, *Sex and Pregnancy in Adolescence*, Sage Publications, Beverly Hills, Calif., 1981.

3. A. Torres, J. D. Forrest and S. Eisman, "Family Planning Services in the United States, 1978–1979," *Family Planning Perspectives*, 13:132, 1981.

4. J. W. Ager, F. P. Shea and S. J. Agronow, "Method Discontinuance in Teenage Women: Implications for Teen Contraceptive Programs," in I. R. Stuart and C. F. Wells, eds., *Pregnancy in Adolescence: Needs, Problems and Management*, Van Nostrand Reinhold, New York, 1982.

5. G. L. Fox and J. K. Inazu, "Patterns and Outcomes of Mother-Daughter Communication About Sexuality," *Journal of Social Issues*, 36:7, 1980; and F. F. Furstenberg, Jr., "Birth Control Experience Among Pregnant Adolescents: The Process of Unplanned Parenthood," *Social Problems*, 19:192, 1971.

6. T. Ooms, ed., *Adolescent Pregnancy in a Family Context*, Temple University Press, Philadelphia, 1981.

7. D. Coughlin and C. Perales, "Family Planning and the Teenager: A Service Delivery Assessment," report to the Secretary of Health, Education, and Welfare, New York, 1978; and E. Herold and M. Goodwin, "Why Adolescents

Go to Birth Control Clinics Rather Than to Family Physicians," *Canadian Journal of Public Health*, 70:317, 1979

8. A. Torres, J. D. Forrest and S. Eisman, "Telling Parents: Clinic Policies and Adolescents' Use of Family Planning and Abortion Services," *Family Planning Perspectives*, 12:284, 1980

9. J. Shea, "An Annotated Bibliography of Family Involvement," report prepared for the Office of the Adolescent Family Life Program, Washington, D.C., 1983

10. F. F. Furstenberg, Jr., 1971, op. cit. (see reference 5), and G. L. Fox, "The Family's Role in Adolescent Sexual Behavior," in T. Ooms, 1981, op. cit. (see reference 6)

11. G. L. Fox, 1981, op. cit. (see reference 10)

12. S. Philliber, "Socialization for Childbearing," *Journal of Social Issues*, 36:30, 1980

13. F. F. Furstenberg, Jr., 1971, op. cit. (see reference 5).

14. G. L. Fox and J. K. Inazu, "Mother-Daughter Communication About Sex," *Family Relations*, 29:347, 1980

15. F. F. Furstenberg, Jr., R. Herceg-Baron and J. Jemail, "Bringing In the Family: Kinship Support and Adolescent Contraceptive Behavior," in T. Ooms, 1981, op. cit. (see reference 6)

16. A. Torres et al., 1981, op. cit. (see reference 3)

17. R. Herceg-Baron and F. F. Furstenberg, Jr., "Adolescent Contraceptive Use: The Impact of Family Support Systems," in G. L. Fox, ed., *The Childbearing Decision: Fertility Attitudes and Behavior*, Sage Publications, Beverly Hills, Calif., 1982

18. G. L. Fox, 1981, op. cit. (see reference 10)

19. R. A. Lewis, "Parents and Peers: Socialization Agents in the Coital Behavior of Young Adults," *Journal of Sex Research*, 9:156, 1973, and G. B. Spanier, "Sources of Sex Information and Premarital Sexual Behavior," *Journal of Sex Research*, 13:73, 1977

20. R. Herceg-Baron and J. Shea, "Mother-Daughter Sex-Related Communications: Implications for Family Planning Providers," report prepared for the Bureau of Community Health Services, Office of Adolescent Pregnancy Prevention, Washington, D.C., 1982

21. F. F. Furstenberg, Jr., J. Shea, P. Allison, R. Herceg-Baron and D. Webb, "Contraceptive Continuation Among Adolescents Attending Family Planning Clinics," *Family Planning Perspectives*, 15:211, 1983

22. G. L. Fox and J. K. Inazu, 1980, op. cit. (see reference 5)

23. J. Shea, R. Herceg-Baron and F. F. Furstenberg, Jr., "Factors Associated with Adolescent Use of Family Planning Clinics," *American Journal of Public Health*, Vol. 74, No. 10, 1984 (forthcoming)

24. R. Herceg-Baron and J. Shea, 1982, op. cit. (see reference 20)

25. G. L. Fox, 1981, op. cit. (see reference 10)

Senator DENTON. I think we might refrain from being categorical in any direction. In other words, take advantage of the observation you have just made and perhaps urge it at first and mandate it later. I cannot yield to a generalization which uses as the point of departure and the point of reference the most difficult situations that we confront nor the most favorable situations that we confront.

Dr. HARDY. True.

Senator DENTON. I originally became interested in this idea of an alternative approach when I saw the latter as having been adopted by the Government in too many of the projects which came under my surveillance.

The most popular sex education movie all over the United States was one which its sponsors indicated was meant only for those people who more or less correspond to your description. But it was being seen everywhere and I think with some harm.

I believe the difficulty might be that the Government really cannot superimpose, as a general rule, its counseling on those parents. Now, we can try to differentiate as we have.

We have tried to take into account the fact that some adolescents have parents who might be abusive, or parents who, because of their attitudes, might be ruled unsuitable parents in the case of some kind of a court action, and that sort of thing.

Perhaps we should discuss the spirit of the law rather than letter of the law but I do think it is an improvement as an alternative to some other programs, and your friend Eunice Kennedy Shriver strongly agrees.

But perhaps aside from our communication today, you would assist us in the area which you have addressed here. I was quite conscious that the gentlemen from Utah in dealing with statistics, which I think were from the Nation, and I cannot confirm their accuracy, but he was insistent that they were overpessimistic regarding sexual activity in a certain age group.

That might be true in Utah but it might be quite the other way in urban Baltimore.

Dr. HARDY. Well, in urban Baltimore, our studies show that 50 percent of seventh graders are sexually active. This is a mind boggling statistic.

Senator **Denton**. Yes; and I am quite aware of that point, and I totally agree with you that each case requires a different perception of its nature.

Dr. **Hardy**. Absolutely.

Senator **Denton**. But I cannot surrender what I believe to be generally mandated by nature or God, if you will, the parental right and obligation to be involved. I cannot see, as I have seen here at this table, counselors pounding on the table and saying, "I demand absolute confidentiality in dealing with that child in sex counseling," and then see the kind of sex counseling that that individual gives. I cannot see mandating that as the rule across this Nation.

Dr. **Hardy**. I am not asking you to do that, because I agree with you.

Senator **Denton**. I know you do. I just wanted to set that limit in my discussion.

Dr. **Hardy**. I think we need to find a way of strengthening the family. You are right on target there. Many of our troubles stem from the disintegration of the family, but we have to take a practical approach in populations where the need is very great.

Senator **Denton**. Yes; and as you know, we are trying to test an alternative approach. The other program encourages parental involvement now as a change made in 1981, but the degree of the encouragement in terms of effect is not known. I am afraid it might not be a very high degree of encouragement in terms of the parents becoming involved.

So we had to mandate consent in this program in order to get an isolated group which I think is being less harmed than the other group as a control group, if you will. There is nothing funny about this, but it is very difficult to deal with it in legislative reality here.

In your written testimony, you indicate that Baltimore has the dubious distinction of having the highest rate of adolescent pregnancy, female-headed single-parent families, and sexually transmitted disease of any city of its size in the country.

I know that you would want me to make this distinction when you talk about the black poor and their needs as distinct from those of other groups. You and I both know heroic young blacks as well as heroic black parents, grandparents, extended family members who exceed many weathy whites, if you will, in their devotion to their children, in their morality and observation thereof. Perhaps this is true because of the tremendous familial tradition of that race, and poverty is not always the most sinful state to be in.

I am sure you would agree with that, although as a generalization.

Dr. **Hardy**. We have data that indicates that the poor white adolescents are not very different from the poor blacks in their behavior.

Senator **Denton**. Yes.

Dr. **Hardy**. I think it is a reflection of conditions rather than race.

Senator **Denton**. Right. I am sure that we could find some interesting facts about wealth. I mean, it is difficult to deal with prosperity, too, as far as this area is concerned.

There have been statistics. They say figures do not lie, but liers know how to figure. And I do not know how to read through them sometimes.

But your testimony has been very helpful this morning, Dr. Hardy, and this room needs to be set up for another hearing. I would like to thank you, and in view of your proximate location, welcome your correspondence, telephone conversations or personal visits to us.

We are trying to do our best in dealing with a difficult and demanding problem.

Dr. HARDY. Well, I would like to congratulate you on the efforts that you are making. I think it is really fantastic and very laudible and I hope you are successful.

Senator DENTON. Thank you very kindly.

This subcommittee will meet again on Thursday, April 26, at 10 in this room, SD-430, to continue hearings on the reauthorization of the Adolescent Family Life Demonstration Projects Act. We will be hearing from interest groups and national organizations. You are all invited to attend.

This hearing is adjourned.

[Whereupon, at 12:55 p.m., the proceedings adjourned to reconvene at 10 a.m., April 26, 1984.]

REAUTHORIZATION OF THE ADOLESCENT FAMILY LIFE DEMONSTRATION PROJECTS ACT OF 1981

THURSDAY, APRIL 26, 1984

U.S. SENATE,
SUBCOMMITTEE ON FAMILY AND HUMAN SERVICES,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:10 a.m., in room SD-430, Dirksen Senate Office Building, Senator Jeremiah Denton (chairman of the subcommittee) presiding.

Present: Senators Denton and Eagleton.

OPENING STATEMENT OF SENATOR DENTON

Senator DENTON. Good morning. This hearing will come to order.

I would like to welcome you to this second oversight hearing on the Adolescent Family Life Demonstration Projects Act, title XX of the Public Health Service Act.

It is the responsibility of the Subcommittee on Family and Human Services to assess the effectiveness of the programs currently operating under the Adolescent Family Life Act.

The subcommittee scheduled 2 days of hearings, the first of which was held on Tuesday of this week, to get a clear picture of the experience to date of activities conducted under the program. The hearings also provide interested grantees and organizations with the opportunity to discuss their perceptions of the need for adolescent sexuality and pregnancy programs in their communities.

The hearings will serve as a basis for reauthorizing the act, which is now scheduled to expire on September 30, 1984.

The Adolescent Family Life Act has three purposes. First, it funds prevention demonstration projects which develop effective programs of sex education that, among other things, include family participation and acknowledge the importance of the family in the decisions of teenage children about sexuality.

Second, the act provides for care demonstration projects to provide comprehensive services to pregnant teenagers, teenage parents, and their families.

Third, the Adolescent Family Life Act supports research into the causes and consequences of premarital teenage sexual relations and adolescent pregnancy.

At the first hearing on Tuesday of this week, administration officials and grantee representatives from across the country discussed their involvement with the demonstration and research projects.

Dr. Edward N. Brandt, Jr., the Assistant Secretary for Health of the Department of Health and Human Services, made it clear that the Department is committed to the principles of the Adolescent Family Life Act's alternative approach to the problems of teenage sexuality and pregnancy. Mrs. Marjory Mecklenburg, the Deputy Assistant Secretary for Population Affairs and Director of the Office of Adolescent Pregnancy Programs, enthusiastically described her work with grantees to establish projects that can provide services to teenagers in accordance with the act's requirements and restrictions.

I deeply appreciate the support of the President of the United States and the Department in the effort to find ways of providing sex education and services to pregnant teenagers through a family-centered approach.

The grantee representatives who testified before the subcommittee emphasized their willingness fully to develop their projects so that the alternative methods providing services to adolescents can be tested and evaluated during an adequate period.

After hearing the testimony of two young program participants, both of whom received care services throughout pregnancy and delivery, I am convinced that the Adolescent Family Life Act is providing services that can help to change the normally devastating condition of teenage pregnancy into a positive and healthy outcome for both the teenage mother and the baby.

The witnesses representing the prevention projects asserted that many teenagers want to learn how to say "no" to premarital sexual relations in the face of peer and other pressures. Preliminary results show that the program participants are exhibiting a less promiscuous attitude toward premarital sexual relations and a more mature understanding of the joys and responsibilities of family life.

Two recipients of research grants discussed the need for improved data on the causes, consequences and most effective means of reducing the incidence of teenage sexual relations, pregnancy and parenthood. One researcher reviewed his findings on the attitudes of pregnancy counselors about the adoption option. Another researcher discussed the use of services in the community by pregnant adolescents and adolescent parents and the need to improve the access to comprehensive services for pregnant adolescents.

I am gratified to know that the people most involved in the development and operation of the Adolescent Family Life projects are encouraged by the results, even though the projects are relatively new and have just begun to set up their evaluation systems.

This morning, we are privileged to be able to hear from a broad and diverse group of organizations active in fields related to the goals of the Adolescent Family Life Act, which are interested in the intent of the act and in its practical application. Many of the organizations present today endorsed the bill when it was first proposed in 1981. I look forward to hearing their views about the current statute and their recommendations about how it might be improved.

There are some organizations that were invited to appear but were unable to do so. Some of those would have testified adversely respecting the bill. Organizations that would have been expected to testify adversely, having requested an appearance at the last hearing and having received invitations from us, somehow chose not to attend. For those who submit testimony we will include their written statements in the hearing record. That applies to all organizations that were invited to appear today, but were unable to do so—not all of them are adversely inclined toward this bill.

Indeed, one such positively oriented organization is the Joseph P. Kennedy, Jr., Foundation. Mrs. Eunice Kennedy Shriver worked diligently with me in 1981 to develop the Adolescent Family Life Act. She, along with the Kennedy Foundation, offered early and essential support for the concept and assisted the efforts in the Congress to pass the legislation. Mrs. Shriver was unable to present testimony today. She did send a letter, and she asked that I read it into the record.

I shall read it rather than just insert it, because I value her previous contributions to date, and her future cooperation in this area and consider her an extremely influential person in this field.

The letter is dated April 25, 1984.

> Dear Senator Denton, I am pleased to urge reauthorization of the Adolescent Family Life Act.
>
> Since adolescent pregnancy legislation was first passed in 1978, I have seen the first-hand, positive contributions that the earlier legislation and Adolescent Family Life Act have made to the enhancement of life for adolescent mothers, fathers, and their babies. Without the existence of such legislation, thousands of young mothers-to-be, their lives already fragile and troubled, would have literally no place to turn for understanding, counseling and moral, emotional, and medical support.
>
> What makes the projects funded under this act particularly effective is their commitment to strong ethical values, to family life, and to a belief that adolescent pregnancy can be dramatically reduced through moral education and example, provided in a caring environment by dedicated teachers, parents and professionals.
>
> I firmly believe that these projects must be funded for at least 3 years, so that they can more adequately demonstrate the effectiveness of their humane and caring approach in addressing the problems of adolescent pregnancy and so that their lasting influence on the lives of these young families may be evaluated over a sufficient period of time—and she is referring to 3 more years.
>
> For the past 3 years, it has been the privilege of the Kennedy Foundation to work with many of the projects established and supported through the Adolescent Family Life Act. In my personal observation, they have become true communities of caring in which young people are shown a moral vision of a better life for themselves and their children.
>
> I trust that the Congress in its own caring will not remove this vital resource from the lives of one of our most vulnerable populations, our children.
>
> I am pleased to submit for the record my own perception of what these communities of caring have achieved over the past 3 years, and why it is imperative their continuity be assured.
>
> Sincerely, Eunice Kennedy Shriver.

That is the end of quote of the letter from the Joseph P. Kennedy, Jr., Foundation.

After the hearing, I intend to join with Senator Grassley and other colleagues to introduce legislation to reauthorize this Adolescent Family Life Demonstration Projects Act for 3 years at the current authorization level, which is $30 million. I expect the cooperation of my colleagues on both sides of the aisle to report the bill quickly from the Labor and Human Resources Committee and to act upon it on the floor.

I welcome the distinguished panel of witnesses to the subcommittee. I look forward to your testimony today and to your support during the reauthorization process.

I want to give all of the witnesses the usual notice, that other Senators who are unable to attend, and perhaps I myself, may wish to submit written questions to be answered within 10 working days of receipt, and the record of this hearing will be kept open until that time.

Our first distinguished witness is Dr. Mildred F. Jefferson, who is the President of the Right to Life Crusade.

She has had many notable accomplishments, known throughout the Nation and internationally. She is an incomparable advocate for the life of the unborn.

It is indeed an honor to have you with us, Dr. Jefferson, and if you have any testimony you wish to deliver orally, please do so.

STATEMENT OF MILDRED F. JEFFERSON, M.D., PRESIDENT, NATIONAL RIGHT TO LIFE CRUSADE, INC., AND ASSISTANT CLINICAL PROFESSOR OF SURGERY, BOSTON UNIVERSITY SCHOOL OF MEDICINE, BOSTON, MA

Dr. **Jefferson**. Thank you, and good morning, Honorable Mr. Chairman.

Thank you very much for the opportunity of appearing before you to speak in support of the Adolescent Family Life Act of 1981 and the reauthorization.

Over the last half century, accelerating to a catastrophic degree in the past decade, our country has been duped into accepting and implementing a theory of population control and reduction which threatens the survival of our people and the existence of our Nation. Although no planning body has ever shown that it was qualified to determine what the optimal population of this country or any other should be or of what constituency, the United States of America has been led by a coalition of nongovernmental organizations and interest groups to accept their untested views unwittingly.

Based in a secular-humanist tradition with an avowed objective of displacing the influence of the mystical religions in our national life, its customs and its laws, particularly the influence of the Judeo-Christian ethical sanctity of life, these organizations have undertaken a sweeping social revolution, using the courts principally, with only very limited help from the Congress. With relatively limited impact in the earlier years, that is, to the point of about 25 years ago, effective use of a nearly inexhaustible supply of private funding to fuel legal challenges and initiatives gave these organizations their two most valuable weapons: the Family Planning Services and Population Research Act of 1980, and the U.S. Supreme Court's decisions on abortion in 1973. By these actions, through two different branches of the Government, our Government has been placed in control of family life in the United States.

Many of those who have initiated legal action in challenging the Adolescent Family Life Act of 1981 are themselves responsible for what they now complain about, because until they put the Government into the business of controlling reproduction and into the business of disrupting the responsibilities of families to transmit to their own young people their values, then the Government was not involved. But with the kind of involvement that is possible through the funding that we can only estimate, the amount of money that is being requested, $30 million, for the Adolescent Family Life Act, is miniscule.

At the point that I sat on the Population Commission that was appointed last by President Nixon and reappointed by President Ford, when we first convened, we asked the Office of Management and Budget if it could tell us the amount of money that came out through our Government in the name of population control. When our Commission went out of existence over a year later, it still was not possible for OMB to give us those figures.

While the organizations that are usually in court to challenge such provisions as this, including an organization that is now the latter day representation of Margaret Sanger's birth control movement, they have millions of private dollars each year, supplemented by government funding at Federal, State, and local levels, to carry out the kind of educational programs, sex education programs, which are not education programs, but are behavior modification programs, and it is this small effort, the Adolescent Family Life Act, that we attempt to make some balance in what has become an abuse of the relationships not only of the family members, but of those who are using the Government attempt to help against those who need that help.

The very least we can do is to start the effort that will make some kind of balance. This is a step. Among our own allies, there is some difference of viewpoint, but I urge all of them to remember what has been the focus in mobilizing the kind of effort which we have undertaken since January 22, 1973. We cannot overnight undo a mechanism and a machinery which has taken almost 22 years to establish, but we can begin the steps to balance it until we can gain the strength to unravel it. And I would like that each of us who would like to take this small step will use whatever influence we can with our own allies to recognize that if we stand and tolerate what we know to be abuse, instead of doing what we can, then we become part of that abuse.

Thank you.

Senator DENTON. I must say, Dr. Jefferson, from my point of view, I have never heard the problem, the situation confronting us, stated more clearly and more accurately, and I wish that what you just said could be said on national television on prime time, every day. I think the promotion of the general welfare requires it. I imagine you are as aghast as I when you recognize that this is the only subcommittee in the entire Senate which happens to have the word "family" in it. The subcommittee has among the things under its jurisdiction, this adolescent pregnancy subject. The cost of adolescent pregnancy is enourmous. At the hearing the day before yesterday, the cost was measured in terms of the care, the medical care, the housing, the counseling, and so on. You and I know, all of us know, in this battle, if you will, that that is a very small fraction of the real cost. And not all of the cost, in fact, not most of the cost, is to be measured in dollar terms. There is a great and tragic cost of happiness to children, to adults, in terms of wrecked marriages and psychological problems. There has developed in this Nation a concept of a breeding rather than a rearing society. And not only can no nation survive that way, indeed civilization itself cannot exist that way. And we in this subcommittee, believe it or not, can devote probably no more than 15 percent of our time to the subject of family, in general, because we have many other topics to address.

To what do you attribute our inability as a society to bring ourselves to tell adolescents, to give them the simple message that premarital sexual relations will lead to problems unforeseen by them, serious problems? I ask the question because it especially pertains only to the age in which we now live; as you said, the rates of adolescent pregnancy are nothing less than devastating and the Government programs other than this one which address the problem do not give that message.

Dr. **JEFFERSON**. I think one of the problems, Senator Denton, is that there has been a breakdown throughout the society of the willingness to take a firm stand. People have really been intimidated and perhaps are now somewhat frightened of their children. In the first place, they do not want to be disliked; they do not want to be considered "not with it," which I suppose is the current terminology. So, instead of establishing what would be standards that the child must live within, they try to suggest that they can go along with whatever the others are doing, and this is a very tragic thing.

One of the most significant abuses that has grown out of what we are trying to correct is the intention from the beginning to give sex education courses to teenagers without parental consent. It is using the emotional hook and exploiting what might be a sensitivity between parents and the adolescent that those who are carrying on this kind of effort break down what has been the communication between the parent and child. So, where the parent may be somewhat reluctant to take the heavy hand, or to look as if they may not be as understanding as some other parents, or something they may have seen on television, or something they may have read about in the peer counseling literature that is passed out, the parent is boxed in, and often, there is no source for that parent to turn to for for reinforcement, and it is just multiplied.

I think that is part of the tragedy of this, because it reflects the larger picture of the parent really not being able to function as the parent, the guide, the example, and so they abdicate the parental responsibility to be another "pal."

Senator **DENTON**. We remain continually aware in these hearings that television, peer pressure, the contents of movies and reading material all contribute to an unfortunate orientation or a presentation of unfortunate role models, of unfortunate situations, of unfortunate ideas, and one has to wonder how much the Nation can tolerate at first, permitting this to continue, much of which is technically illegal, but no one has the guts to call a spade a spade, and second, the Government initiating policy nominally to address the problem which does nothing less than feed the fire, in the opinion of many.

The Census Bureau, according to an article in the Washington Post today, just released a study that shows that the out-of-wedlock pregnancy rate has doubled since the mid-forties in this country. For women who are now 25 to 29 years old, 38.5 percent of the babies born to them when they were under 20 years old were out-of-wedlock, and that is the highest rate of out-of-wedlock births for all age groups of women. It is evident from these statistics that we must do more to assist teens in understanding the responsibilities of parenthood, particularly as two-parent families, rather than just accepting the alarming status for young mothers and children reported by the Census Bureau.

Can you tell me why so many in the medical profession and in the pregnancy counselling profession insist on such strict confidentiality when providing services to minors?

I would acknowledge, as you implied, that the parent-to-child channel of sex education is not necessarily ideal, indeed, has traditional limitations, I would suppose, historic limitations. But at the time of decision on the part of a 13- or 14-year-old girl, at the time of her indoctrination by authorities who she regards as reputable, believable, the government advocates a policy which, in my opinion, constitutes the worst kind of interference in the family. This is something that cannot be addressed even by the separation of powers, because in nature itself, there is no government, except perhaps a totalitarian one, which can properly see itself within its system as interposing itself between the parent and the child. I am not going to give up on this issue. I find that there are tactical compromises that must be made for the sake of getting a better approach accepted and getting it done quickly. I want you to know that, Dr. Jefferson.

Dr. JEFFERSON. I understand that.

Senator DENTON. But it sickens me.

Have you any comments about the pregnancy counseling professionals insisting on strict confidentiality when dealing with adolescents? They demand to be able to ignore the parent while they fill that child with what you regarded or named as, perhaps, secular-humanism, or maybe something even worse. I have seen movies and literature which could not be considered just neutral, but are definitely pushing teenagers toward premarital sexual activity. This is coming across even in PG movies—fun sex is outside of marriage, marriage is the beginning of trouble. The old movies used to end where they got married and lived happily ever after. Now they start out with an unhappy marriage and show how much fun they have breaking it up.

Dr. JEFFERSON. This is why I refer to it as not "sex education," but "behavior modification." They take what I think of as the "cooking school approach," and the consequence is what happens in cooking school: You try out what you have just cooked. But they recommend the education and say that they are not moralists. But we know from the experience in Scandinavia that whenever anyone undertakes such programs without trying to instill a sense of moral accountability, it results in increased pregnancies out-of-wedlock, increased venereal disease, increased abortions, and this can be repeated every time we look at such studies.

I know, or I believe, that there is something of an ulterior motive in the focus of the peer counselors and the others that you speak of, even some of my colleagues who are of that mind, because the objective is to have a child in a circumstance where she will not, or he—because sometimes young men are exposed to this—they will not have any balancing counsel either from their parents or someone that their parents may trust to do so.

If you suggest that I am being a little unkind with that observation, notice the different tack that is taken in other aspects, where you would expect someone to keep the details of one's private life private, then they will broadcast this far and wide, but when it comes to the matter of protecting the minor and making sure that a parent or guardian would be in a responsible position to advise, then the cloak of privacy and secrecy is drawn. I do not believe any ethical physician would treat an adolescent, a minor, an unemancipated minor, without the knowledge and consent of a guardian. But those who now may do so in the area of reproductive treatment or treatment of the reproductive system or contraceptive treatment, I think that would only be fear of the litigation that might ensue, if such young person were related to any of the advocate organizations. But I do not feel that there is the genuine concern for the privacy and welfare of that minor.

Senator DENTON. And all this is due, in my view, to the fortuitous, for their ends, positioning of highly qualified professionals, in the legalistic sense, with the knowledge of how to lobby. They are a minority of activists who have a value system which is so far removed from that of the average citizen that it is almost incredible that they have been able to assume control of the situation.

I believe you mentioned this, but for the record, do you believe that the demonstrations being carried out under the Adolescent Family Life Act have a good chance to help change this tide?

Dr. JEFFERSON. I believe that they do, because there have to be steps; people have to know that there is a source available. And just by having a project which is having an effect that can be demonstrated is one way of making a statement. It at least sets for the record that those who are concerned have made a small step forward to balance what it has taken approximately 50 years to get off-track. And by having experienced researchers, highly qualified people, with the prestigious credentials, to begin to create the information, to establish the projects, and to have the living proof of that in the young women who have been helped, I think this is very, very necessary and very important.

Senator DENTON. I am being requested by Senator Thurmond, who is the chairman of the full Judiciary Committee, to recess this hearing for 10 minutes so that I can help that committee reach a quorum. There are many issues which they must take up. This contingency arises more frequently than is convenient, but I will hope that I will be back here in no more than 10 minutes.

I want to thank you, Dr. Jefferson, for your extremely valuable testimony, and I am going to recess the hearing now until 5 minutes to 11.

Thank you.

Dr. JEFFERSON. Thank you.

[Short recess.]

Senator DENTON. The hearing is reopened. I do not anticipate another interruption, but the subcommittee has been delayed in the process of this hearing, and there is another hearing scheduled in this room for 2 p.m., for which there needs to be considerable prepreparation.

So in the interest of time, I must ask—and I think these lights will function—that the witnesses restrict the duration of their oral remarks to 5 minutes.

Written testimony—and I say this with respect to each witness and all witnesses—written testimony prepared for presentation will be entered in the record as if read.

I thank all of you for your cooperation in advance.

Senator DENTON. Our next witness is Mr. Richard Van Deelen, the corporate secretary of the National Committee for Adoption. Mr. Van Deelen is accompanied by William Pierce, Ph.D., president of the organization.

I have had a history of associating and working with the national committee since the beginning of my senatorial term here, and I especially welcome the opportunity to receive your recommendations, as well as any criticisms you might have, of public policy relevant to us this morning.

Please begin, Mr. Van Deelen.

STATEMENT OF RICHARD VAN DEELEN, CORPORATE SECRETARY, NATIONAL COMMITTEE FOR ADOPTION, AND REPRESENTATIVE, BETHANY CHRISTIAN SERVICES, ACCOMPANIED BY DR. WILLIAM PIERCE, PRESIDENT, NATIONAL COMMITTEE FOR ADOPTION

Mr. VAN DEELEN. Mr. Chairman, it is an honor to be here today to testify in support of the Adolescent Family Life Act and to urge its reauthorization.

The National Committee for Adoption is a national voluntary organization concerned about the issues of adoption and services to young, single, or troubled parents. I also have the pleasure of being associated with Bethany Christian Services, a voluntary agency with its headquarters in Grand Rapids, MI. Bethany, to the best of our knowledge, is the largest adoption agency in the United States. In 1983, we were instrumental in finding adoptive homes for 575 children. These children included healthy infants, children with special needs, and children from other countries.

Bethany also provides various services to young, single, or troubled parents, including pregnant adolescents, through a network of agencies, a network of offices, and with the assistance of concerned volunteers who offer their homes to foster these young women.

We also provide residential maternity services.

Because the National Committee for Adoption has had the pleasure of testifying before this subcommittee on previous occasions, we will not repeat the detailed background information about the organization. We would like to make five major points with regard to this legislation.

First, we were early and enthusiastic supporters of the concept of this act. We realized that if we are to cope with the increasing incidence of teenage pregnancy, we needed not only to continue the sound health and other human services programs which had been created by the predecessor legislation offered by Senator Kennedy; we needed to go further. The Adolescent Family Life Act did go further. It took the concept of providing adoption services to those young women who wanted this option and emphasized its potential.

For the first time in many years, there was a strong Federal statement in favor of adoption as an alternative for young, pregnant women.

You built on the history of the subcommittee, which had taken strong steps to encourage the adoption of children with special needs, under its previous chairman, Senator Cranston. Just as we supported the thrust of legislation aimed at improving adoptive opportunities for children with special needs, we support your legislation which is aimed at improving adoption opportunities for children of teenage mothers. We supported that legislation, as we still do, because we believe that pregnant adolescents desperately need more and better services, and that adoption is one of the services most-needed by these young women.

From our viewpoint, the support of the Adolescent Family Life Act was wise. In the first few years, important steps have been taken to focus attention on the pregnant adolescent and those affected by the pregnancy. Existing care programs have been continued, supplemented, and expanded, and excellent beginnings have been made in the area of prevention.

We are seeing at least partially as a result of the focus of this law, a multifaceted response growing in our society to the problems caused by adolescent pregnancy. Key researchers and service providers are calling for more programs aimed at convincing young people to delay sexual activity, and promising research is being conducted, research that can assist us in improving the focus of our efforts.

Second, we support the law and its reliance on the voluntary sector to deliver services. We fully recognize the controversy which has arisen about the delivery of some of these services by sectarian grantees. We are deeply concerned about this development. We believe that some of the more effective and innovative approaches to human problems are provided by the sectarian agencies in our country.

All one needs to do is look at the past battles against social problems in our society, whether those battles were against health problems or other foes, and the role of the sectarian agency has been critical.

Moving on, we would also add that we have such a very strong private sector in this country. We believe it should be allowed to continue to provide services, whether under nonsectarian or sectarian auspices.

In my State and others, sectarian agencies like Bethany play a vital role in the service delivery system. We believe that should be continued.

Third, we support the continuation of this act essentially as it is. We believe that the reauthorization of funds should be given so that projects can continue and be completed.

Fourth—and I am about to conclude—we believe that authorization should be at a higher level.

Thank you.

[The prepared statement of Mr. Van Deelen follows:]

NATIONAL COMMITTEE FOR ADOPTION
SUITE 326
1346 CONNECTICUT AVENUE, N.W.
WASHINGTON, D. C. 20036
202 - 463-7559

Mr. Chairman, it is an honor to appear today before your Subcommittee on Family and Human Services. My name is Richard Van Deelen. I am the corporate Secretary of the National Committee For Adoption, Inc. Accompanying me is William Pierce, President of the National Committee For Adoption. We are here today to testify in support of the Adolescent Family Life Act and to urge its reauthorization.

The National Committee For Adoption is a national voluntary organization concerned about the issues of adoption and services to young, single or troubled parents. We are a membership organization, composed of voluntary agencies providing these services, as well as of concerned individuals. Our member agencies provide these services in more than 100 locations in 40 states and the District of Columbia. I also have the pleasure of being associated with Bethany Christian Services, a voluntary agency with its headquarters in Grand Rapids, Michigan. Bethany Christian Services is, to the best of our knowledge, the largest adoption agency in the United States. In 1983, for instance, we were instrumental in finding adoptive homes for 575 children. These children included healthy infants, children with special needs and children from other countries. Bethany Christian Services also provides various services to young, single or troubled parents, including pregnant adolescents, through a network of offices and with the assistance of concerned volunteers who offer their homes to foster these young women. We also provide residential maternity services. Because the National Committee For Adoption has had the pleasure of testifying before this Subcommittee on previous occasions, we will not repeat the detailed background information about the organization.

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First, we were early and enthusiastic supporters of the concept of this Act. We realized that if we are to cope with the increasing incidence of teenage pregnancy, we needed not only to continue the sound health and other human service programs which had been created by the predecessor legislation authored by Senator Kennedy, we needed to go further. The Adolescent Family Life Act did go further. It took the concept of providing adoption services to those young women who wanted this option and emphasized its potential. For the first time in many years, there was a strong Federal statement in favor of adoption as an alternative for young, pregnant women. You built on the history of the Subcommittee, which had taken strong steps to encourage the adoption of children with special needs under its previous Chairman, Senator Cranston. Just as we supported the thrust of legislation aimed at improving adoption opportunities for children with special needs, we supported your legislation which aimed at improving adoption opportunities for children of teenage mothers. We supported that legislation, as we still do, because we believe that pregnant adolescents desperately need more and better services and that adoption is one of the services many need most.

From our viewpoint, the support of the Adolescent Family Life Act was wise. In its first few years, important steps have been taken to focus attention on the situation of the pregnant adolescent and those who are affected by that pregnancy. Existing care programs have been continued, supplemented and expanded. Excellent beginnings have been made in the area of prevention -- beginnings which give the lie to those who attempted to bury the law in ridicule. No one is laughing now. Rather, we are seeing, at least partially as a result of the focus of this law, a multifaceted response growing in our society to the problems caused by adolescent pregnancy. Major Black organizations are focusing on the problems of adolescent pregnancy in the Black community. Key researchers and service providers are calling for more programs aimed at convincing young people to delay sexual activity. And promising research is being conducted -- research that can assist us in improving the focus of our efforts.

3.

Second, we support the law and its reliance on the voluntary sector to deliver services. We fully recognize the controversy which has arisen about the delivery of some of these services by sectarian grantees. We are deeply concerned about this development. We believe that some of the more effective and innovative approaches to human problems are provided by the sectarian agencies in our society. All one needs do is look at the past battles against social problems in our society -- whether those battles were against health problems or other foes -- and the role of the sectarian agency has been critical. It is important that, so long as grantees carry out the intent of Federal legislation, all grantees -- non-sectarian and sectarian alike -- be permitted to play an appropriate role. This large voluntary sector, the independent sector if you will, has been a key to the progress of our society. The independent sector's versatility and flexibility, its creativity and diversity, have served our pluralistic society well. Indeed, many observers believe that the role of the independent sector is one of the reasons for the success of our nation -- especially in the area of human services. Other nations have not been so fortunate. For instance, an article in last week's Wall Street Journal, commenting on the challenge that Sweden is facing in dealing with its future social service problems, said that Sweden was struggling with ways to invent an independent, voluntary sector.

We have such a sector. It must be allowed to continue to provide services, whether under non-sectarian or sectarian auspices. In my state and others, sectarian agencies like Bethany Christian Services play a vital service delivery role. And in the nation's largest city, there is a long and honorable tradition of service provision by the sectarian voluntary agencies -- Jewish, Protestant, Roman Catholic.

We countenance no abuses -- just as we hope you will tolerate no harassment -- in the independent sector.

4.

Third, we support the continuation of this Act essentially as is. The demonstration programs which have been initiated need to have time to succeed -- or fail. But they need that time in a fair context -- a context that does not change the rules or the themes half-way through. We believe that it is important to resist the temptation to substantially rewrite this legislation, even though all of us, program administrators, legislators, grantees, and advocates alike, might have some ideas about ways to change and improve the law. We can try those changes after we have given these programs a fair test. We certainly have no need to fear that the underlying problem of adolescent pregnancy which these programs address will vanish, no matter how successful these demonstrations may be.

No, we need to ensure that we will be able to evaluate the successes and failures of the programs funded by this Act by giving the Act and these programs an opportunity to go their prescribed course.

Fourth, we support a funding authorization which is substantially higher. We believe that there are many additional programs, care programs, prevention programs, and research programs, which could be funded if more money were provided. For this reason, we have consistently testified before Appropriations in support of additional appropriations for this law. We believe that if we can achieve a higher authorization level, perhaps it will be easier to convince your colleagues to appropriate at a higher level.

We suggest that you double the authorization level. We would like that to translate into a doubling of the level of effort of the Office of Adolescent Pregnancy Programs. Many more worthwhile programs could be funded. Demonstrations should be launched in each state and with each target group. Additional resources must be given to the fight to prevent teenage pregnancy. And we need a much larger and more aggressive research effort. It would be our hope that more earmarking be done of these funds, so that some of the key problem areas could be more aggressively addressed. For instance, we believe that funds should be earmarked for national evaluation of the effectiveness of the programs authorized and funded by the Act. At least five percent of funding should be

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reserved for this purpose. We also believe that a specific earmark of funds for prevention should be considered -- the earmark might be in the area of twenty percent. And, because adoption services are a critical but still under-funded area of activity, we believe that at least twenty percent of the appropriated funds should be earmarked for programs and research related directly to adoption services. We have other ideas for targeting these funds which we would be glad to discuss with you, other members of your Subcommittee, or with Subcommittee staff.

Fifth, we support a broadening of the Act's scope in terms of coordinating related programs within the Federal government. The several efforts scattered through the Federal government -- efforts which, in sum, are vastly larger in financial outlays than the modest expenditures under this Act -- need to be better organized and better coordinated. We fully recognize the difficulty of mandating such coordination, particularly when there are very large programs, such as AFDC, which expend hundreds of millions of dollars annually in services to adolescent mothers and their children. Well-intentioned attempts to coordinate Federal programs have been made before -- and have foundered, usually because the various program administrators were unwilling to collaborate. We encourage you to build into the reauthorization of this Act strong language requiring coordination. Perhaps, by working with the Director of the Office of Adolescent Pregnancy Programs, the Secretary of Health and Human Services and others, the Subcommittee can devise a workable coordination mechanism. We strongly encourage you to focus on this problem and to build into the law such authority as may be needed to achieve this goal.

Your leadership in this area is paying off. The adoption services -- services which build strong families, families which are demonstrably able to rear good citizens -- which have been funded under this Act are having a ripple effect. Others are considering the role of adoption services when they plan programs

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for pregnant adolescents. Not just within the programs funded by Federal money but all across the nation, existing programs and new programs are starting which feature adoption as a key component. And more and more young women -- in every part of the country, of every race -- are picking adoption as their plan. More and more young women are looking at the harsh reality of single, teenage parenthood and what it does to their own lives -- not just their babies -- and deciding on the adoption option.

At Bethany Christian Services, as with hundreds of new programs which are starting every year, the positive impact of your leadership in the adoption area is evident. Just as we have grown and flourished (and we are providing attachments which explain several of our most effective programs, including our national hotline) so have others -- thanks to the favorable, pro-adoption environment which has resulted from the Adolescent Family Life Act.

We thank you for your leadership on behalf of young, single and troubled parents as well as pregnant adolescents. Your work is paying off in better lives for many young women and their babies.

Attachments:

(Editor's Note: Due to printing limitations, and in the interest of economy, the attachments accompanying this statement were retained in the files of the committee where they may be researched upon request.)

Senator DENTON. Thank you, Mr. Van Deelen. Your testimony was perceptive, in my view. You talked first about support derived from your interest in improving adoption opportunities, and then, asserted that excellent beginnings have been made in the area of prevention, which really does not help you in the adoption community.

And, in your prepared testimony, you mentioned "those who attempted to bury the law in ridicule" and say "No one is laughing now." No, they are not. The laughs have turned to scowls, to bridling, to attacking. And there is plenty of money and many people, behind it. We are in the middle of that battle, and we very much appreciate your comments, because yours is a highly respected organization.

You expressed your concern about those attacks, and having scanned your written presentation, I am sure that it will be a very important part of the record of this hearing, and I want to thank you both for it.

Would you elaborate on the ways that additional earmarked funds could be used for programs and research related directly to adoption?

Mr. VAN DEELEN. I would like to defer to Dr. Pierce on that.

Dr. PIERCE. Senator, there are a couple of ways that that could be done. One thing that we would like to suggest is that some small portion of the authorization, and therefore the piece that is designed for appropriation, be earmarked. I would say $1 million or $2 million, at least, of actual appropriation money.

There are some very exciting things being done in adoption research, but we need more, and it needs to be more targeted.

The second part of my answer, I would suggest that it is very difficult for researchers to really be able to respond when they have to respond to a request for application or a request for proposal, that is all mixed up with the whole of services included in your bill. It would be good if we could have a separate RFA just for adoption programs.

The third part of my answer is that however the Department and the Office of Adolescent Pregnancy Programs would decide to judge between competing applicants, I think it is very important that there be real peers who make those judgments, and the best way to have the proper peers is to make sure that the research panels, if they continue to use the NIH approach, are made up of people who are adoption experts not just in academia, but adoption experts in the field of providing services, because what we are after here is services, not just ivory tower responses.

Senator DENTON. During the course of these hearings, I have learned about some very useful activities in research being carried out under the Adolescent Family Life Act. I certainly hope that these positive examples and research results will be made known and made known widely, because Federal judges are affected by what they read, and legislators are affected by what they receive from their constituents. I have been particularly oppressed, not only in this subcommittee, but in the one on security and terrorism, by the effectiveness of a boycott, or the effectiveness of a distortion which is applied, and therefore, the manifestation of truth seems to stop here in this hearing room.

Do you have any recommendations—I ask this almost desperately—for the wider dissemination of examples and research results on this subject, because this is really the pivotal point for legislative decision. It affects not only the adoption field, although there is an extremely important feature of this issue which bears directly on adoption, and that is the reversal of the old trend to put 97 percent or so of the children up for adoption, which was the case when I was a youth, and the reverse now. So it is necessary to try to get this information disseminated. I must be candid—a number of so-called pro-family organizations have not exceeded themselves in disseminating the information, either because it is not directly related to what they are doing, or, as Dr. Jefferson implied, they perceive this, unfortunately, as an effort on my part to interpose the Government in this problem. I don't want to. I only want to correct the Government's already-established position in this problem. I think it could be better handled at the local level. I think it could probably be handled even with less Federal expense than is presently the case. I believe that people would like it that way. But that is not the point of departure. We are departing from another point in which the Government is massively involved, and in order to make that correction, there has to be some sort of alternative program which this represents.

Do you have any comments on how we might be able to disseminate the truth of what is revealed at these hearings?

Mr. VAN DEELEN. I want to just comment as an agency executive and someone who is aware of what is happening at the line, and that is that the vast majority of counselors, whether they are in family planning clinics or in crisis pregnancy programs throughout the United States today, are woefully inadequate in understanding adoption. They have had no exposure to it, or very little. And therefore, what we are finding is that the adoption option is just mentioned at best. It is not presented in such a way that it really becomes a viable possibility for most girls today.

So I am not sure how to disseminate the information—I think Dr. Pierce will have a comment—but there is a tremendous need to educate the counselors who are spending time with the girls who are coming in for services, because the option has to be presented well and knowledgeably, or it is not viable.

Senator DENTON. Something just occurred to me, if I may interpose a remark. Dr. Pierce, you have on your Board a person whose name and position in the media I will not mention, but I would think that the couple to whom I refer immediately arise to your consciousness, and I wonder if something could not be done about dissemination.

Dr. PIERCE. You are right, Senator. I will take your suggestion. I think it is a good one.

I think that one of the things that is important to understand—I used to work for the Federal Government many years ago—is that if we are going to spend Federal money to do all of these programs, that we should not leave the results of those expenditures to sit on shelves in the bureaucrats' offices.

I worked for the old Office of Economic Opportunity, and one of the things that we did was to send out information, not at the end of the project, necessarily, when it might be too late to really help, but we sent out the results of progress reports so that we could keep the field informed. I think if you could encourage the Office of Adolescent Pregnancy—and it is tough, with the limited dollars and staff that they have— if you could encourage them to really do dissemination programs, if they cannot do it with their own staff, then to contract it out, to make sure that the material gets out there, and not just to the title XX grantees, and not just to the people who are interested in it from a profamily point of view, but to also the folks who are in the title X projects. There are 5,000 clinics around the country. Those clinic counselors, a lot of them are volunteers, and they need the opportunity to be able to have information that they can share, and I think an information dissemination response would be great.

Senator DENTON. Well, I received a lot of flack from the right when I got together with members of an organization named NFPHRA. I think there will be some apologies forthcoming from the people who delivered the criticisms. But I do not regard anyone in title X or in the associated programs, the grantees, as diabolical, fixed in a mindset which is irretrievably different from my own. They might evolve to a position which I could personally endorse. Nor do I mean to take the condescending position that I am omniscient, and certainly, I do not want to impose my beliefs or values upon any organization. But I believe that progress can be made in the manner to which you refer, with respect to parental involvement—which is now encouraged in title X, but not carried through, in my view, to the degree that even the mention of encouragement could warrant. Indeed, progress must be made, because they have the funding. There is not the consciousness on the floor of this body, nor on the floor of the House, of what the title X this program consists of.

Dr. PIERCE. I would like to make a comment, if I might, Senator, about what you have just said. We had a speaker at our conference, which we are having at this time, who is from a family planning grantee that is really involved in comprehensive services. This family planning grantee has taken the step of involving not only its people in talking about the adoption option; they have gone the extra step to become a licensed adoption agency. They have already placed this year, 10 children for adoption. If all of the title X grantees were to have just that level of effort, we would have 20,000 more children adopted into homes per year. I think that is an extremely important opportunity for collaboration between the title X grantees and the title XX grantees.

Senator DENTON. It certainly is, and were I king—and I do not wish to be, because this is a democracy—I would, if I had to make the arbitrary decision, change certain things. But I want to make it clear that I do not think my own program—our own program—has necessarily ironed out all of the kinks. We have tried to express qualifications by providing exemptions of certain types of parents who should not be involved, but we have only tried. There are some other kinds of parents that I can think of now—well, we have said parents who are likely to be abusive were they aware; we have said parents who would likely be ruled unsuitable parents in a court action should not be involved. But there may be other ways that we have to qualify that. But I think that beginning with the idea that the Government cannot, for the sake of the general welfare, should not as a general rule demand exclusive confidentiality in dealing, through their counselors, with the children on the subject of sex at the time of decision on the part of the children involved. I say that we should start with the premise that parents should be involved, and then try to qualify that, rather than say the counselor should have exclusive confidentiality, and then somehow qualify that to let the parents in. And that is the way the title X program functions right now. We are only encouraging the involvement of parents in title X. I have very little knowledge or faith in the degree to which those parents are involved, but I am willing to be convinced, and I hope it is an increasing rate. And in the adoption field, the same thing. I just believe there have been some in the counseling field who are not interested in either issue, and the more they thin out and the others who believe in different approaches increase numbers, the more likely those programs are to improve.

In the interest of very tight time constraints, I must thank you now for your testimony.

Mr. VAN DEELEN. Thank you, Senator.

Dr. PIERCE. Thank you, Senator.

Senator DENTON. I would like to welcome now our next witness, Mrs. Mercedes Wilson, whose excellent reputation is widespread and about whom I have read a great deal. She is the executive director of the Family of the Americas Foundation in Covington, LA, and I deeply appreciate her decision to take the time and effort to be here this morning, and I look forward very much to your testimony, Mrs. Wilson.

STATEMENT OF MERCEDES WILSON, EXECUTIVE DIRECTOR, FAMILY OF THE AMERICAS FOUNDATION, COVINGTON, LA

Mrs. WILSON. Thank you very much, Mr. Chairman.

It is an honor and a privilege for me to testify on behalf of the Adolescent Family Life Act.

Mr. Chairman, my name is Mercedes Arzu Wilson, executive director of Family of the Americas. Our organization is the recipient of a grant from the Department of Health and Human Services entitled "Fertility Appreciation for Families." This is a prevention service, national demonstration project, which will develop, test, and disseminate a comprehensive educational program to assist parents to become better informed and more effective in providing sex education to their children; teach adolescents about their fertility, the importance of protecting their capability for procreation, and encourage them to accept responsibility for their sexual behavior.

Mr. Chairman, the teenage birth rate in the United States is among the highest in the world, surpassing those of many lesser developed nations. In the 1960's, there were 92,000 births to unmarried teenagers——

Senator DENTON. Mrs. Wilson, excuse me. Let me make a remark about that. The teenage birth rate in the United States is among the highest in the world, surpassing those of many lesser developed nations. I believe that that fact transcends the indication that was mentioned yesterday about the apparent difference between poverty and less poverty on this. I know that there is some understandable effect, but then, I think that distinction is transcended by other distinctions, such as the mores, the cultural environment, as it respects this problem. And you, I think, made that very clear in that one sentence. Nations with much less quality of living, much lower standards of living, have lower premarital birth rates than the United States of America.

Mrs. WILSON. In 1979, there were 263,000 births to unmarried women, almost a tripling of the 1960 figures. In 1973, there were 244,000 legal abortions performed on pregnant unmarried teenagers. In 1980, there were 460,000, a near doubling of the rate.

We can compare the 1979 rates of teenage live births and abortions as such: 263,000 live births to unmarried teens and 461,000 abortions to unmarried teens. This means there were slightly less than twice as many abortions as births of illegitimate children.

Evidence seems to indicate that as Federal spending on family planning increases, so do teenage pregnancies. In Sweden, for instance, where sex education and contraceptives are available to all children in grade school, and where day care support is universal, premarital sexual activities are the norm. Today, Sweden has a divorce rate 60 percent higher than that in the United States. Half of all pregnancies end in abortion, and of those children who are born, one-third are born out of wedlock.

There are nearly 5,000 family planning centers throughout the United States which provide family planning methods and provide or refer for sterilization and abortion. According to the National Center of Health Statistics, the largest group using family planning clinics are women under the age of 20. Each year, 1 of every 10 teenage girls becomes pregnant throughout America; nearly 1 out of every 10 people suffer from sexually transmitted diseases. Because of the increase in sexual promiscuity, the demand for contraceptive devices and abortions has steadily increased, and so has Government funding for them. Over $2 billion per year is spent to treat sexually transmitted diseases.

Mr. Chairman, even with these statistics in front of us, and even with the divorce rate we all know about, there is a vast number of people in this country who believe in chastity, self-discipline, and marital fidelity. If 50 percent of our young people are sexually active, what about the other 50 percent who choose chastity and virginity until marriage? What are we doing for them?

We feel that the Government, by funding grants such as ours, has taken a positive step to support and serve another section of the population—a section that chooses to reserve itself sexually until marriage.

Professor Armand Nicholi, Jr., of Harvard reports that:

> Many who have worked closely with adolescents over the past decade have realized that the new sexual freedom has by no means led to greater pleasure, freedom, and openness, more meaningful relationships between the sexes. Clinical experience has shown that the new permissiveness has often led to empty relationships, feelings of self-contempt and worthlessness. Others have found that although their sexual behavior by and large appeared to be a desperate attempt to overcome a profound sense of loneliness, they described their sexual relationships as less than satisfactory and as providing little of the emotional closeness they desired. They de-

scribed pervasive feelings of guilt, and haunting concerns that they were using others and being used as "sexual objects."

The sexual union is the most intimate of all human interactions, and it contributes to the deepening relationship of a married couple. By its very nature, the sexual act is both unitive and generative. By excluding the generative function of sexual union, it opens up sexual activity to purely recreational purposes. Once sexual activity becomes purely recreational, it loses its total purpose; it is no longer unitive and no longer generative.

Mr. Chairman, this country was founded on high human and spiritual values. We wish to affirm these values and reverse a trend that seems to downgrade the importance of the family. A strong, productive nation is built on strong productive families.

It is imperative that the family be protected, and the family must take steps to see that the laws and institutions of any State do not offend, but rather, support and defend the family's rights and duties. We are the designers of the future, and we must assume the responsibility for forming and transforming society.

I do not know if you wish me to stop right now, or to finish.

Senator DENTON. Well, you have had the 5 minutes, and in all fairness, perhaps I can scan the rest of your testimony and, to be technically fair, ask you questions which bring out your points.

Mrs. WILSON. Surely.

[The prepared statement of Mrs. Wilson follows:]

TESTIMONY OF MERCEDES WILSON

FAMILY OF THE AMERICAS FOUNDATION, INC.

Mr. Chairman, Members of the Committee,

My name is Mercedes Arzu Wilson, Executive Director of Family of the Americas Foundation. Our organization is the recipient of a grant from the Department of Health and Human Services entitled Fertility Appreciation for Families. This is a prevention service, national demonstration project which will develop, test, and disseminate a comprehensive educational program to:

- assist parents to become better informed and more effective in providing sex education to their children;
- teach adolescents about their fertility, the importance of protecting their capability for procreation, and encourage them to accept responsibility for their sexual behavior.

The main purpose of our project is to develop a program for parents to enable them to be the primary sex educators of their children from birth to adulthood. We will also develop a curriculum for adolescents, ages 10 to 14, based on their developmental needs.

A standardized program will be taught in centers throughout the country and will be evaluated to determine its effectiveness to meet the needs of each area.

Mr. Chairman, the reasons this program was proposed to the Department of Health and Human Services are many.

The teenage birth rate in the United States is among the highest in the world, surpassing those of many lesser developed nations. In 1960, there were 92,000 births to unmarried teenagers in the U. S. In 1970, there were 200,000 and in 1979, there were 263,000 births to unmarried women -- almost a tripling of the 1960 figures. In 1973, there were 244,000 legal abortions performed on pregnant unmarried teenagers. In 1980, there were 460,000 abortions performed on pregnant unmarried teengers -- a near doubling of the rate. We can compare the 1979 rates of teenage live births and abortions as such: 263,000 live births to unmarried teens and 461,000 abortions to unmarried teens. This means there were slightly less than twice as many abortions as births of illegitimate children.[1]

Evidence seems to indicate that wide availability and knowledge of contraception have, in many ways, been responsible for creating this problem and increasing the number of teen pregnancies.

As federal spending on family planning increases, so do teenage pregnancies. "In New York State, in 1982, 66,000 teenagers experienced pregnancy. About half had abortions. More often than not, the others dropped out of high school. Two-thirds of those will be on welfare in five years. Their children will be disadvantaged, too. They're more likely to have a low birth weight and a lower I.Q. and repeat at least one grade in school. As one of those young mothers put it recently, 'We need help, and we can make it if someone says "We can give you a second chance."' There'd be no need for that second chance if those teenagers had availed themselves of a first chance - to avoid pregnancy. The legislature has approved $5 million contingent on specifics about how to spend it. The Governor deserves congratulations for a fresh approach to an old, and often tragic, problem."[2]

The Journal of Reproductive Medicine, December 12, 1983, reported that more than half the women exposed to contraceptive information do not make use of that information. "A study of 1,000 women presenting themselves for first trimester abortion at a Preterm Clinic in Boston, MA found that 55.7 percent of the patients had not used any type of contraception for three or more months prior to conception. The remaining 44.3 percent were using some form of birth control, and hence, pregnancy was a result of contraceptive failure. Nearly all the women in the study acknowledged that they had acquired some knowledge of contraception. However, why they were not making full use of this information is not known. This confirms that teenagers are not using contraceptives, and that, therefore, massive contraceptive programs are a failure.[3]

In Sweden, where sex education and contraceptives are available to all children in grade school, and where day care support is universal, premarital sexual activities are the norm. Today, Sweden has a divorce rate 60 percent higher than that in the United States. Half of all pregnancies end in abortion, and of those children who are born, one-third are born out of wedlock. It is often the girls that pay the highest toll as they are usually left with a child that they must take care of for the rest of their lives.

There are nearly 5000 family planning centers throughout the United States which provide "family planning" methods and provide or refer for sterilization and abortion. According to the National Center of Health Statistics, the largest group using family planning clinics are women under the age of 20. Over 73 percent of the under 20 women never used or did not regularly use any method of birth control before visiting the clinic. After visiting the clinic, 79 percent of these women adopted oral contraceptives.[4]

Even with this extraordinary commitment to family planning and sex education, more than half of all teenage girls are sexually active. Each year, one of every ten teenage girls becomes pregnant. Throughout America, nearly one out of every ten people suffer from a sexually transmitted disease. Because of the increase in sexual promiscuity, the demand for contraceptive devices and abortion has steadily increased and so has government funding for them. Over $2 billion a year is spent to treat sexually transmitted diseases.[5]

Mr. Chairman, even with these statistics in front of us, and even with the divorce rate we all know about, there is a vast number of people in this country who believe in chastity, self-discipline, and marital fidelity. If 50 percent of our young people are sexually active, what about the other 50 percent who choose chastity and virginity until marriage? What are we doing for them? We feel that the government, by funding our grant, has taken a positive step to support and serve another section of the population -- a section that chooses to reserve itself sexually until marriage.

Professor Armand Nicholi, Jr. of Harvard reports that "many who have worked closely with adolescents over the past decade have realized that the new sexual freedom has by no means led to greater pleasure, freedom, and openness, more meaningful relationships between the sexes. Clinical experience has shown that the new permissiveness has often led to empty relationships, feelings of self-contempt and worthlessness, an epidemic of venereal disease, and a rapid increase in unwanted pregnancies. They have noted that students caught up in this new sexual freedom found it unsatisfying and meaningless." In a more recent study of normal college students (those not under the care of a psychiatrist), Nicholi found "that although their sexual behavior by and large appeared to be a desperate attempt to overcome a profound sense of loneliness, they described their sexual relationships as less than satisfactory and as providing little of the emotional closeness they desired. They described pervasive feelings of guilt and haunting concerns that they were using others and being used as "sexual objects."[6]

Dr. Joseph Santamaria, Director, Department of Community Medicine, St. Vincent's Hospital, Melbourne, Australia comments that "the sexual union is the most intimate of all human interactions and it contributes to the deepening relationship of a married couple. Within this union, procreation is a joint sharing in the preservation of the human species, and so intimate is this relationship, in its inbuilt power to share in procreation, that it is recognized as being exclusive of all others. Fidelity is essential to the continuing commitment of the spouses' life-long union. By its very nature, the sexual act is both unitive and generative. By excluding the generative function of sexual union, it opens up sexual activity to purely recreational purposes. Once sexual activity becomes purely recreational, it loses its total purpose; it is no longer unitive and no longer generative. It has become a source of physical pleasure with no true meaning to the lives of the two persons involved."[7]

Mr. Chairman, this country was founded on high human and spiritual values denied by other European nations. We wish to affirm these values and reverse a trend that seems to downgrade the importance of the family. A strong, productive nation is built on strong productive families.

It is imperative that the family be protected, and the family must take steps to see that the laws and institutions of any state do not offend, but rather support and defend the family's rights and duties. We, the families, are the designers of the future, and we must assume the responsibility for forming and transforming society. We must retain the right to bring up our children according to our own traditions, our religious and our cultural values. After all, Mr. Chairman, the United States is a Judeo-Christian country, which cherishes a strict code of moral ethics that opposes premarital sex, all kinds of sexual perversions, and abortion.

It is important to point out, when we are talking about human rights, that it is explicitly stated in The Universal Declaration of Human Rights [Article 26, No. 3]; parents have the prior right to choose the kind of education that shall be given to their children.

With confidence in the American family and its future, the Fertility Appreciation for Families project, without any hesitation, believes that parents are the primary disseminators of sexual values to their children, particularly because only they know best when their children are ready to absorb this vital and responsibility-carrying knowledge. This project proposes to strengthen parents in the idea that they can communicate with their children at all ages and to help them develop the skills to do this.

Private and government programs must respect parents' moral values and oppose practices that are contrary to parents' religious principles and beliefs. Surveys taken in secular entities that provide contraceptives, sterilization, and abortion to teenagers, have shown that 46 percent of the people working in those institutions have counselled minor children in favor of abortion without parental consent, or counselled for abortion as an alternative. Forty-one percent of the respondents said that they referred minor children for abortion without parental consent. This is threatening to the rights and authority of the parents.

If we expect young people to obey the law of the land, discipline is the number one priority. They must discipline themselves to respect and follow the rules of sports. They must discipline themselves with respect to time and study in academics in order to succeed. And they must discipline themselves to abstinence in matters of sexual behavior.

The Fertility Appreciation for Families project, working primarily through parents, proposes to present to parents and to 10 to 14 year old children, knowledge and understanding of a future that contains for them self-esteem through positive accomplishment rather than self-disgust because of premature sexual activities that lead to venereal disease, unwanted pregnancies, loss of family trust, a feeling of guilt, and personal unhappiness.

To encourage young adults to use contraceptives is a course of action destructive to them, their futures, their future families, and the entire country.

There are many young people today that want to choose chastity as their premarital state, and seek supportive counselling. Because "freedom" is such a catch word used by those who are in favor of premarital sex, I would like to point out the freedoms that chastity provides.

1. Freedom from unwanted pregnancy
2. Freedom from complications of the pill and IUD
3. Freedom from venereal disease
4. Freedom from early sterilization from either V. D. or unwanted pregnancy ,
5. Freedom from complications of abortion
6. Freedom from forms of genital cancer
7. Freedom from the stigma and sorrow that befalls a family with an unmarried pregnant daughter
8. Freedom to explore cerebrocentric rather than genitocentric sexuality

"Nature has dictated that young people are physically able to reproduce as soon as they become teenagers. They must be taught that intelligence and self-control are essential. Total success in avoiding unwanted pregnancy, abortion, venereal disease, complications of the pill and IUD depends not upon further advances in technology, but upon a strong national program stressing the advantages of discipline."

"It would be a strange society indeed if the government said cigarettes are wrong, alcohol is wrong, drugs are wrong, lying, stealing, and all forms of violence are wrong, but in sex, you can do no wrong."

"It is the job of parents and educators to assure young people that they are capable of leading ordered and responsible sexual lives, propaganda to the contrary not withstanding. Everyone has a responsibility to his own body, to the welfare of those he loves and is responsible for, and to society at large, including the generations to come."

"Of far greater value to the health care of our teenagers would be the government's leadership role in a national program to protect their inner reproductive organs by the most effective and least expensive form of birth control, sexual abstinence."

"Along with the rights of reproductive freedom, comes responsibility and with responsibility comes rewards.

"The need for self-discipline in sexuality is no different from the need for that trait in every other aspect of our daily lives."[8]

"The physical, social, and psychological consequences that befall the unwed mother and the family, plus the internal dissension within the family, generated by an illegitimate birth, will, in our program, be presented to the parents to help them teach the value of avoiding such an event to their own children. When self-motivation and self-regulation in sexual life are practiced and understood as inherently right or good, they become the natural virtue of chastity."[8]

Mr. Chairman, there exists a tremendous contrast between the voluminous information disseminated by the various advocates of premarital sex and the lack of information and agencies advocating and supporting premarital chastity among young people. The inundation of the public - via newspapers, magazines, radio and TV, and the movies, with stories and articles with marked emphasis on sex, sexual freedom and the advocacy of new sexual mores, is apparent to all and subject young people to an unfair and unjust psychological assault. Our program, Fertility Appreciation for Families, begins to redress this disparity. Physicians, parents and educators should be equally well-informed about the reasons for supporting chastity as they are on the other methods of birth control. The government has no wish, I am sure, to neglect half our teenage population. Our program is crucial to the future of our country.

References

[1] *Statistical Abstract of the U. S.*, U. S. Department of Commerce, Bureau of the Census. 1982-83.

[2] *New York Times*, April 4, 1984.

[3] *Journal of Reproductive Medicine*, Vol. 28, No. 12, December 1983: pp. 847-850

[4] "Women Who Use Organized Family Planning Services" Hyattsville, MD: National Center for Health Statistics, 1969: pp. 12-13.

[5] Department of Health and Human Services: unpublished report

[6] Harvard Book of Modern Psychiatry, p. 532.

[7] Santamaria, J. N. *Human Love and Human Life*. Melbourne: University of Melbourne, International Conference on the Family. 1978.

[8] Wilson, Mercedes Arzu. *The Ovulation Method of Birth Regulation* New York: Van Nostrand Reinhold Company, 1980. pp. 109-110.

Appendix

Comparison of Venereal Disease Rates from 1960 - 1980[1]

Syphilis (Primary and Secondary)

	1960	1980	
Ages 10 - 14			
Males	30	51	
Females	105	117	- 1.24 times higher
TOTAL	135	168	
Ages 15 - 19			
Males	1303	2014	
Females	1274	1562	- 1.3 times higher
TOTAL	2577	3576	

Gonorhea

Ages 10 - 14			
Males	1190	2199	
Females	2068	6674	- 2.72 times higher
TOTAL	3258	8873	
Ages 15 - 19			
Males	30649	99904	
Females	23000	147245	- 4.6 times higher
TOTAL	53,649	247239	

Senator DENTON. You indicate thar it is your belief that parents are the primary disseminators of sexual values to their children, particularly because they know best when the children are ready to absorb this vital and responsible knowledge, and you indicate that this project proposes to strengthen parents in the idea that they can communicate with their children at all ages and help them to develop the skills to do this.

In my own mind, most explicitly, although, as I have said before, I am not convinced that parents in general are always excellent communicators on this subject, but I do believe that the Government should permit them to enjoy their right, exercise their privilege, and I believe, exercise their ability to give advice more efficiently at the time when there is a true crisis. It is one thing to be talking to a child theoretically at 7 or 12 or 14, if you think that child is just hearing it in a situation posing no special danger, if you will. It is another thing to know that that child is at the point of decision, is receiving counseling which is not in accordance with, as you pointed out, the parents' traditions, religions, and cultural values, and I believe that is highly improper.

Mrs. WILSON. Yes, Mr. Chairman. I believe the rights of the parents should never be usurped. I think nobody knows their child better than a parent. However, the propaganda today is making them feel inept to exercise these rights. And this is why our program is geared primarily to parents, to help them, advise them, encourage them, and give them the security that they are not to just sit down with their teenagers when they reach a certain age; it is an educational process that starts from the very beginning of life.

Senator DENTON. One doctor in here, at a previous hearing, said—and this bears on the distinctions that we might otherwise think that it is dangerous to draw the line between children 13 and children 17, because neither is really that equipped in terms of experience and analysis, to evaluate thoroughly the consequences of making the wrong choice. He went on to say that in his view—and he had something like 45 years of counseling experience, as well as being—I think he was a medical doctor—he said, "You know, I have a son 35 years old, and I still feel that I have to exercise my parental responsibility." My mother is 81, and when she wishes to make her views clear to me, I do listen. Perhaps I listen better than I did when I was 17 or 14. So that parental responsibility, I believe, is endless, and inalienable.

Mrs. WILSON. Absolutely. In fact, I agree 100 percent with what you just said, and I also feel that if we can advise the parents that if they give them a lot of love, affection and attention, that will be the greatest deterrent for any child doing anything wrong, because they will not want to hurt their parents, and they will not want to disappoint their parents. And this is why we should also inculcate the importance of discipline. Discipline is part of the love. If they love the children, they will want to discipline them, and this is very much what our program will be based on, on helping the education of the parents, parenting their children.

Senator DENTON. Why do you think it is relatively difficult for parents and their children to talk about sex?

Mrs. WILSON. Well, the reason why this is not a very easy subject—it was not even easy for me with my own children, even though I am involved in this work—but I feel that if you educate the parents well, it is going to be a much easier task, because it is not something that you speak to them about at a certain age, but that you bring up gradually, and you talk to them when they want the questions answered. This has been, I am sure, a very successful way of doing it.

Senator **Denton**. Yes, I thoroughly agree. In other words, parents need education—-there has been a change, of which they may be much less aware. If social workers, doctors, teachers get together with parents and work on this, and professionals in other fields involving the parents, same sort of values, you think that from that curricula or consultation something could develop a dialog that would be superior.

What or who do you think could have the most positive influence on a young person who has been engaging in premarital intercourse to change his or her behavior?

Mrs. **Wilson**. I think some of the most important points to be made to children when we go to the schools, and that I think impress them the most, is the truth—how they are made, how their anatomy and physiology works; the brain controls the reproductive organs, of which science still knows very little, 2 or 3 percent, that any effects of any artificial methods of birth control like the pill, are going to be affecting their brains as well, which are still growing and maturing. So this is the way we do our education. We teach them the anatomy and physiology, the effects of artificial contraception, the effects of venereal disease, of which they are ignorant, and the effects of abortion, not only physical but psychological.

Senator **Denton**. Well, there are some devices which tend to discourage lawsuits being brought by parents who could make a case that this private advice about, let's say, the use of birth control pills, given to their children by a government-funded source and resulting in harm for the child, insufficiently cautions about the likelihood of the consequences. I don't think many parents are aware of that recourse.

Mrs. **Wilson**. This is why it is important to educate the parents, because so often, we hear that parents themselves encourage their children to use them. But if the parents knew the consequences, no parents would be willing to harm the health of their own children. Also, we encourage the advantages of chastity, the freedom from unwanted pregnancy, the freedom from complications of artificial methods, such as the pill and the IUD; freedom from venereal disease. It is really a matter of telling them the truth.

Senator **Denton**. Yes, the movies used in sex counseling that I have seen and the predominant literature push the idea that there should not be an unnecessary constraint upon natural impulses and on the happiness that results from sexual indulgence. And as you say, happiness does not result. You can get some pleasure, but you can also get other effects, which submerge the importance of that momentary pleasure. In other words, in the long range, or relatively short range, the goal of the pursuit of happiness is not served.

So, I am not for suffocating, and I am not against love or against sex, nor against the normal sexual development. But there is just no question that the situation is in chaos today, and it is not being put in a true perspective. And the word truth is the one I would emphasize. I wish we had more time to discuss this problem.

We will be submitting you written questions, to which we hope to receive answers. I earnestly wish you well in your project. I hope it proves successful in this area of parental involvement, and I look forward to receiving reports of your progress, and I hope we use more than this hearing room as a means of communication.

I would like to thank you very much.

Mrs. WILSON. Thank you very much, Senator Denton.

Senator DENTON. Our next witness is from my beloved home State, Mr. John Carr, of Birmingham, AL, and I would like to extend him a very special welcome.

He is the Director of Lifeline Children's Services, an adoption agency, and more recently, also, a maternity home. Lifeline Children's Services has placed 55 children in adoptive homes since January of 1981. I would like to commend you, Mr. Carr, in this official environment, for the service you are performing in Alabama and surrounding States.

We are ready to hear your statement, sir.

STATEMENT OF JOHN H. CARR, DIRECTOR, LIFELINE CHILDREN'S SERVICES, BIRMINGHAM, AL

Mr. CARR. Thank you, Senator Denton.

I appreciate very much the opportunity of being part of these hearings, and we in Alabama are very pleased with the national leadership which you have given in trying to do something about this national problem of teenage pregnancy.

Lifeline is an adoption agency, licensed by the State department of pensions and security. We work very closely with Sav-A-Life, which started in Birmingham in 1980, and in the past 3½ years, over our hotline, we have received over 14,600 calls just in the Birmingham area alone. This generally indicates very clearly part of the problem that we have with teenage pregnancy.

The Subcommittee on Family and Human Services is to be commended for passing the legislation known as the Adolescent Family Life Act of 1981. Although funding for the program has been minimal, and certainly, not commensurate with the extent or severity of the national problem of teenage pregnancy, substantial results were achieved. We understand that 18 months' duration of projects is not an adequate time in which to have a full evaluation of the program, but we do know that some significant results have been achieved during this 18 months. According to the evaluation conducted by the Urban Institute, the OAPP projects had a lower infant mortality rate, fewer lower birth weight babies were born, fewer clients had repeat pregnancies, and educational goals were comparable to older and more advantaged women.

I would like to comment on several sections of the bill under consideration and suggest ways by which the bill perhaps could be strengthened.

Section 1901(b)(2) states that one of the major features of the AFL bill is to promote adoption as a positive option for adolescent parents. Research has shown that of the four options available to the pregnant teenager, the adoption option is considered to be the least desirable, and the first option rejected. Since 1973, the availability of the legal abortion and our society's permissive attitude toward the unwed pregnant teenager has made adoption an even less-favored option.

Prior to 1973, most adoption agencies were content to let their clients come to them. Provision of care services was often separate from the adoption service. In order for adoption to be presented as a viable alternative, it must be done as part of the counseling program, and with as much enthusiasm and conviction as given to the other options.

In 1982, I had the opportunity to review and evaluate 15 project grant applications for OAPP funding. I was impressed and rather concerned that, at least in the applications that I reviewed, adoption was one of the weaker parts of the projects.

I recommend that in reviewing and approving grant applications for funding, those applicants which present a strong adoption component be given careful consideration. No option has more potential for benefiting the unmarried mother, the father of the baby, the baby himself, and last, but certainly not least, the adoptive couple who have waited for years to receive a child to complete their family.

It is my understanding that a small percentage of the money allocated for research and data collection was spent to determine why so few young parents chose the adoption option for their babies. This data is urgently needed in order to effect changes in the public and private agencies providing adoption services, and to inform in a more effective way the teenagers who are confronted with an unwanted pregnancy.

There should be money provided in S. 1090 to purchase the technical services needed to develop grants and to evaluate them. There are probably many agencies and programs which could contribute to the body of knowledge being sought by S. 1090, but which do not have the staff or expertise to write the application and meet the requirements as stated in S. 1090. Many of the applications I reviewed were obviously being written by staff members preparing their first grant application. This gives an unfair advantage to large organizations and institutions who employ staff for the purpose of writing grant applications. Regional workshops could be scheduled to train and assist those persons and agencies needing such assistance.

One of the objectives of this bill is to provide the States with a workable model for similar comprehensive programs. Although Alabama has had an OAPP project for the past 2 years, I have not seen or heard any information about the project. State and local governments need to be informed about OAPP projects in their area so they can get involved and be ready and willing to continue the projects when the demonstration project funding ends.

Thank you for giving me this opportunity to testify on behalf of the Adolescent Family Life bill of 1981. I look forward to the reauthorization of this bill and to a continuation of the programs which have had such a promising beginning.

Thank you.

[The prepared statement of Mr. Carr follows:]

lifeline
Children's Services
A Wales Goebel Ministry

SENATE HEARING CONDUCTED BY
SUBCOMMITTEE ON FAMILY AND HUMAN SERVICES

On Re-authorization of
The Adolescent Family Life Act of 1981

April 26, 1984

Honorable Jeremiah Denton
United States Senator

Ladies and Gentlemen:

My name is John H. Carr. I am Director of Lifeline Children's Services, a child-placing agency licensed by the Alabama State Department of Pensions and Security. Lifeline counsels and assists those teenagers and women who are experiencing a crisis pregnancy and who have turned to Lifeline Children's Services for help in placing their children for adoption. Lifeline works closely with Sav-A-Life, a crisis pregnancy screening and counseling program which started in December, 1980 in Birmingham, Alabama. Sav-A-Life organizations are now located in twelve other cities extending from Florida to Texas (See attached list for addresses of Sav-A-Life organizations). Lifeline and Sav-A-Life operate as a part of the Wales Goebel Ministry, a non-denominational ministry which provides alternatives to abortion.

From December, 1980 through March, 1984, Sav-A-Life of Birmingham has received 14,609 telephone calls over its Hotline which operates twenty-four hours a day, seven days a week. These calls are received and responded to by trained volunteers. (See attached Sav-A-Life Ministry Profile). The experience of working with the problem of teenage pregnancy during these past three years is the basis for our observations on the need for such a program and how it can be improved upon.

This Subcommittee on Family and Human Services is to be commended for passing the legislation known as The Adolescent Family Life Act of 1981. Although funding for the program has been minimal, and certainly not commensarate with the extent or severity of the national problem of teenage pregnancy, substantial results were achieved.

According to the evaluation conducted by the URBAN INSTITUTE the clients served by OAPP projects had: 1) a lower infant mortality rate; 2) fewer low birth weight babies were born; 3) fewer clients had repeat pregnancies, and 4) educational goals were comparable to older, more advantaged women.

I would like to comment on several sections of the bill under consideration and suggest ways by which the bill could be strengthened. These recommendations are based on my experience during the past three years of managing a crisis pregnancy

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counseling program and adoption agency.

Section 1901.(b)(2) states that one of the major features of the AFL bill is to promote adoption as a positive option for adolescent parents. Research has shown that of the four options available to the pregnant teenager the adoption option is considered to be the least desirable and the first option rejected. Since 1973 the availability of the legal abortion and our society's permissive attitude toward the unwed pregnant teenager has made adoption an even less favored option. Prior to 1973 most adoption agencies were content to let their clients come to them for service. Provision of care services was often separate from the adoption service. In order for adoption to be presented as a viable alternative it must be done as part of the counseling program and with as much enthusiasm and conviction as given to the other options.

In 1982 I had the opportunity to review and evaluate fifteen project grant applications for OAPP funding. None of these applications had an emphasis on adoption. It appeared that adoption was included as an afterthought in order to satisfy the requirements of the bill. I recommend that in reviewing and approving grant applications for funding those applicants which present a strong adoption component be given careful consideration. No option has more potential for benefitting the unmarried mother, the father of the baby, the baby himself, and last, but certainly not least, the adoptive couple who have waited for years to receive a child to complete their family.

It is my understanding that a small percentage of the monies allocated for research and data collection was spent to determine why so few young parents chose the adoption option for their babies. This data is urgently needed in order to effect changes in the public and private agencies providing adoption services, and to inform in a more effective way the teenagers who are confronted with an unwanted pregnancy.

There should be provided in S.1090 monies to purchase the technical assistance needed to develop grants and to evaluate them. There are probably many agencies and programs which could contribute to the body of knowledge being sought by S.1090, but which do not have the staff or expertise to write the application and meet the requirements as stated in S.1090. Many of the applications I reviewed were obviously being written by staff members preparing their first grant application. This gives an unfair advantage to large organizations and institutions who employ staff for the purpose of writing grant applications. Regional workshops could be scheduled to train and assist those persons and agencies needing such assistance.

I understand that not less than 1% and not more than 3% of each applicant's grant funds is to be spent to evaluate each project. I recommend that 5% of the monies appropriated for OAPP be designated for the evaluation of the total OAPP. This would provide more monies to determine the overall effectiveness of the legislation, and make possible a fuller accounting to Congress and to the public.

One of the objectives of this bill is to provide the States with a workable model for similar comprehensive programs. Although Alabama has had an OAPP project for the past two years I have not seen or heard any information about the project. State and local governments need to be informed about OAPP in their area so they can get involved and be ready and willing to continue the projects when the demonstration project funding ends.

Thank you for giving me this opportunity to testify on behalf of the Adolescent Family Life Bill of 1981. I look forward to the re-authorization of this bill and to a continuation of the programs which have had such a promising beginning.

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SAV-A-LIFE MINISTRY PROFILE

Month and Cumulative Totals

	MARCH 1984		Dec. '80 to Date	
I. HOTLINE CALLS:	Amount	%	Amount	%
A. Crisis	291	41 %	6,401	44 %
B. Non-Crisis	96	14 %		
C. Client - Counselor	65	9 %		
D. Other	254	36 %		
E. Post-Abortion	5	0 %	29	.001 %
Total	711	100 %	14,609	100 %
II. NEW APPOINTMENTS:				
A. Made	194		3,654	
B. Kept	100	52 %	1,852	51 %
C. Walk-ins	18		246	
III. PREGNANCY TESTS:				
A. Positive	65	60 %	722	46 %
B. Negative	39	35 %	718	46 %
C. Inconclusive	6	5 %	120	8 %
Total	110	100 %	1,560	100 %
IV. PREGNANCY:				
A. Counseling				
1. Accepted	30	25 %	548	28 %
2. Declined	88	75 %	1,378	72 %
Total	118	100 %	1,926	100 %
3. Clients Last Month	100			
1. Accepted	30			
4. Became Inactive	(20)			
Total in Program	110	100 %		
B. Personal Data				
1. Unmarried	92	78 %	1,436	75 %
2. Married	26	22 %	483	25 %
Total	118	100 %	1,919	100 %
3. Minors (Under 19)	34	30 %	502	26 %
4. White	60	51 %	1,130	59 %
5. Other Races	58	49 %	789	41 %

Senator DENTON. Thank you, Mr. Carr.

Dr. Edmund Mech, the day before yesterday, discussed the findings of research he conducted on the orientations of pregnancy counselors toward adoption. His research indicated that the counselors favored adoption, but there were two limitations on their ability to successfully advise for or counsel toward adoption. The first was a lack of objective knowledge about the adoption process on the part of the counselors. The second was a sense or perception on the part of the counselors that adoption was not a popular option in the minds of the pregnant young women or the young mothers, and hence, they reasoned that until there is a market existing among adolescents for counseling about adoption, they are not going to be that positive about counseling it.

How can we express to adolescents our positive understanding of adoption so that there will be a demand for adequate adoption counseling, and how can we improve the level of knowledge about the adoption option to the counselors?

Mr. CARR. That is a rather involved question, Senator Denton, but it is one that I have been concerned about from the very beginning.

I think it is interesting that our agency, Lifeline Children's Services, as an adoption agency, developed 2 years after the pregnancy counseling program began in Birmingham. And it came about because we recognized that there was a gap in the attitudes and the information and knowledge that the pregnancy counselors had about adoption, and not having that knowledge, they made a very weak and sometimes completely inadequate explanation of adoption as an option.

We cannot expect these teenagers to make an informed decision about themselves and their babies if they are not given all the information about the options.

So I think that those who are involved in the pregnancy counseling programs must become informed about adoption and present the option in a positive manner. It is for this reason that we have in-service training programs for our counselors. I have an opportunity to talk to them about adoption and to answer their questions and to urge that they present it as an option.

Senator DENTON. Do you feel that the Adolescent Family Life Act's emphasis on adoption can help to overcome the misperceptions and the lack of knowledge about the adoption option, and the low percentage of adoptions?

Mr. CARR. I certainly do. I think the research about adoption is going to be particularly valuable, because as we find out what some of the restraints are in these young girls choosing adoption, then and only then can we bring about changes in the agencies and individuals who are concerned with adoption.

Senator DENTON. I just want to clear up my own uncertainty about one set of statistics. I have frequently said that there are lines of prospective adoptive parents waiting to adopt children, with the means to provide for them well, and with the extra love which adoptive parents have, and then I have often been corrected by people who walk up to me after the hearing and say, "Well, Senator, you are under a delusion. There are lots of people waiting to adopt young, healthy, white children, but for black children or mixed blood children, that is not the case."

I have looked into that to a degree, and I have found that they are wrong, that both black and white parents are there, now, waiting to adopt young black and young mixed blood children, that the problem with willingness to adopt, eagerness to adopt, tends to develop when the children become older and are caught up in the foster care system.

Do you generally agree with that?

Mr. CARR. Yes, sir. Fortunately, in our kind of work, we are dealing only with infants—black, white, mixed race. It is harder to find suitable couples to adopt the black children and the mixed race children, but it is certainly easier if you are dealing with infants than with the older children in foster homes.

Senator DENTON. Well, then, there are programs needed with respect to the black and mixed blood children, and such programs exist.

The "One church, one child"—Father Clements from Chicago, in his original testimony here years ago, was admired and encouraged by me to continue his efforts, and they are worth repeating for this record.

He decided that he wanted a program by which his church would adopt one child in Chicago, one black child, and he talked about the responsibility, you know, "If black is beautiful, then black ought to be responsible, and let us stop apologizing about our backgrounds and our environment and our excuses for this, that, or the other, and let us show what beauty really is, let us show what love is."

His aim was to get his church to adopt one child. I think they adopted 17 after the one sermon. He then came here, and I felt that his program deserved Government help. I am all for private sector initiative, but just to pay the expenses of someone as devoted and effective as Father Clements is a better way, in my belief, to expend the funds than to create bureaucracies of the professionals who are currently involved in Government programs, with less devotion and less spontaneity. He has since adopted a second of his own children, and he has received a Government grant and is now going around the country promoting his idea.

So I believe there is prospect and potential for success in this area, and I hope we emphasize an effort in that direction.

I want to thank you very much for your testimony, Mr. Carr, and I will be seeing you back in Birmingham soon, I hope.

Thank you very much.

Mr. CARR. Thank you, Senator.

Senator DENTON. Senator Eagleton has been tied up on the floor, but he wants to welcome you, Miss Sullivan, and here he is right now, speaking of the man of the hour.

Your witness is here, Tom.

STATEMENT OF HON. TOM EAGLETON, A U.S. SENATOR FROM THE STATE OF MISSOURI

Senator EAGLETON. Mr. Chairman, thank you.

I will be very brief, and I hope I have not interrupted your orderly procedures.

I am honored to introduce to you, Mr. Chairman, Miss Anne Sullivan of St. Louis. She is very active in the work of Catholic Charities in St. Louis, which is one of the many fine philanthropic and humanitarian organizations functioning in the St. Louis metropolitan area, and Miss Sullivan has done extraordinarily good work for that organization, and I think will be an informative and useful witness before this committee.

I am delighted to present her to you.

Senator **Denton**. Thank you, Senator Eagleton.

Senator Eagleton has a history of tremendous achievement on this committee. I consider him a friend—and you could not have come in at a more miraculously precise time.

Senator **Eagleton**. Thank you, Mr. Chairman.

Senator **Denton**. Miss Sullivan, please proceed.

STATEMENT OF ANNE SULLIVAN, CHAIRMAN, COMMISSION ON SERVICES TO UNMARRIED PARENTS, NATIONAL CONFERENCE OF CATHOLIC CHARITIES

Miss **Sullivan**. Thank you, Mr. Chairman.

I hope I can live up to Senator Eagleton's words of praise.

I am a social worker and the director of Professional Services with Catholic Services for Children and Youth in St. Louis. I also serve as chairperson of the Commission on Services to Unmarried Parents of the National Conference of Catholic Charities.

I have spent most of my professional life dealing with the social problems connected with pregnancy. Last year, our agency served over 600 clients ages 17 and under. With a family based approach, this means we impacted over 2,000 residents of our community. However, we reached only a small number of the population who became pregnant, as there were approximately 1,500 live births to girls 17 and under in our region, a significant proportion of the 4,100 live births in the area.

Parenthetically, there was a mistake in my written testimony. We had more than 4,000 live births in the State of Missouri. That was just in the 10-county region centered around St. Louis.

I testify today as a representative of the 156 diocesan member agencies of the National Conference of Catholic Charities, 127 of whom provided pregnancy-related services to 69,000 clients in most of the 50 States. We estimate that about one-third of this client group were adolescents under the age of 17. Our programs range from residential programs with specialized services, including adoption, community-based programs, and programs networking with schools or hospitals. We have a long tradition of commitment to services to this population group, based on family involvement and family values. We serve clients through pregnancy and beyond, with the birth family system, within the context of marriage, or through adoption.

Our programs are diverse, in response to needs within the community. Common to all is a recognition that pregnancy forces many decisions on those directly involved. Such decisions are primarily those of the adolescents, but also, heavily involve their parents. The crisis of pregnancy can cause stress and conflict in family systems and increase the need for family counseling, and we respond to this. The public and private cost of pregnancy in adolescents is of concern to all of us.

Many adolescents and their families choose abortion as a relatively inexpensive, private, and apparently, simple solution to the crisis. For many, this choice is made reluctantly, because of pressures seen as overwhelming. The subsequent cost in terms of emotional and social reactions are still not known to us completely.

Some teenagers opt for marriage. Others do not. All of them need support from within the family, from the community, and the church, public and private charitable welfare systems, schools, and medical care systems.

In rural areas, there is often a scarcity of such resources. In urban areas, there may be a multiplicity of resources and programs, which can cause confusion. Access to services may be difficult. Medical care is a serious problem. Cutbacks in State and Federal funding have impacted on many programs serving this population group. The challenge of locating needed services and accessing into them is difficult, even for professionals.

Social climate and peer pressure support plans for many adolescents to rear the child. Adoption is considered "chicken" and proves beyond the capacity of many adolescents. To face grief and pain which is self-inflicted, or which is to a large extent determined by parents' refusal to assume parental responsibility for a grandchild, is not accepted behavior for adolescents.

Presenting adoption as a viable alternative to pregnant adolescents and their parents is an important part of service delivery and the support for this in the Adolescent Family Life Act has been very important. The stress on networking and linkaging of services, and the recognition of the conflicts in communities regarding the appropriateness and rightness of solutions and services currently available was a welcome effort to involve as many community groups as possible in dealing with adolescent pregnancy. We supported it initially, and continue to do so. We urge reauthorization of the act and increased funding for the program.

The money spent on this act is a small amount relative to the need, but it has an impact in communities where the projects exist, and in many other communities, because of the forward thrust of these programs. Within the Catholic Charities network, four agencies received grants under the act in 1982 and 1983. They offer comprehensive care programs, one with a special focus on strengthening the adoption option, and family-based prevention programs. In these, adolescents and their parents are involved in sessions which stress communication within the family. When they hear their own values discussed and hear those with others, with similarities and differences existing in families, they can develop skills not previously developed or refined, to deal with each other openly and honestly. These skills will be an asset in many situations, not just in dealing with adolescent sexuality.

The programs staff know the services they offer are effective in their goals and reach the population they are intended for. However, with the small amount allowed for evaluation, it is difficult to provide good documentation of program results. Our recipients urge that resources for evaluation be strengthened.

We wish that the dollars available for the Adolescent Family Life Program were more adequate when we consider the extent of the need and the high cost of providing the services. We believe firmly that when we are given the opportunity to provide services and intervene at the earliest possible moment, and with the right mix of services, we can effect more positive outcomes for these children in pregnancy prevention or in comprehensive services to the pregnant adolescent and her child.

Senator DENTON. Thank you very much, Miss Sullivan.

[The prepared statement of Miss Sullivan follows:].

TESTIMONY
of
National Conference of Catholic Charities
by
Anne Sullivan
Catholic Charities of St. Louis
before the
Subcommittee on Family and Human Services
of the
Committee on Labor and Human Resources
The United States Senate
on the
Reauthorization of the Adolescent Family Life Act
April 26, 1984

My name is Anne Sullivan. I am a social worker and Director of Professional Services with Catholic Charities in St. Louis as well as serving as Chairman for the Commission on Services to Unmarried Parents for the National Conference of Catholic Charities. I have spent most of my professional life dealing with the social problems connected with pregnancy. Over the years, our St. Louis program has evolved into a comprehensive range of services, with linkages to medical and school systems. In 1983, our agency program served 2,500 mothers and fathers and their families. Of that total number, we estimate that 600 were adolescents, and with our family based approach, we had an impact on approximately 2,000 residents of our community. However, we recognize that our agency, and other programs in the area, reached only a small number of the population who became pregnant, even in the area of special concern for young parents. Estimates show that there were approximately 1,550 live births to girls 17 and under in our region, a significant portion of the live births in the state which numbered 4,103. Of even more concern is the fact that these young mothers were probably over-represented in the already high proportion of mothers who receive inadequate prenatal care. Looking at the high number of abortions occurring among teenagers also makes the problem of teenage pregnancy a serious one in our community.

Our program is one of several in the community concerned with the problems of adolescent pregnancy. All involved agencies find that the need exceeds our resources to provide the services required. Providing the comprehensive services needed by this group of clients and their families is very difficult.

I testify today as a representative of the 156 diocesan member agencies of the National Conference of Catholic Charities, 127 of whom provided pregnancy related services in most of the 50 states. These agencies reached 69,000 clients in 1982. If I assume that the rate of teenage pregnancy as found in our community is typical, about one-third of this client group were adolescents. The programs of our member agencies are diverse, ranging from residential programs with specialized services, community based programs, and programs networking with schools or hospitals. Our agencies have a long tradition of commitment to services to this population group based on values held by the church and the community. Our commitment to family involvement and to family values is strong, and our programs have focused for many years on involving the family as well as other persons directly concerned with the pregnancy.

Over the years a small group within our National Conference, originally known as the Association of Catholic Maternity Homes, has evolved into a Commission on Services to Unmarried Parents. Our members serve clients of various ages through the pregnancy and beyond with services to the birth family systems, within the context of marriage, or through adoption. Our programs have developed in diverse ways in response to needs within the community. Common to all is recognition that pregnancy forces many decisions on those directly involved, and includes other family members. The range of options includes whether to terminate the pregnancy or to bear the child, to marry or to not marry, to plan adoption for the child or to rear the child with or without the help of the family. Decisions also arise with regard to school and completion of education plans. The availability of and ability to pay for medical care needs to be resolved.

Such decisions are primarily those of the adolescents, but also heavily involve their parents. The crisis of pregnancy can cause stress and conflict in family systems and increase the need for family counseling. The private and public cost of pregnancy in adolescence is of concern to all of us who are aware of the impact on the children and youth involved, on the families, and on society in general.

Many adolescents and their families choose abortion as a relatively inexpensive, private, and apparently simple solution to the crisis. For many, this choice is made reluctantly, because of pressures seen as overwhelming. The subsequent cost in terms of emotional and social reaction are still not known to us completely. Even in the medical area, there are still many unresolved questions about the physical effects of abortion. Some teenagers do opt for marriage. In Missouri in 1982 there were 8 marriages where both parties were 15 years old, and 24 where both were only 16. I suspect these marriages may have been pregnancy related, and thus subject to many stresses. Such marriages need family and community support. Those not choosing marriage are perhaps even more vulnerable. There is need for support from within the family, from the community and the church, the public and private charitable and welfare systems, also involving schools and medical care systems.

In rural areas there is often a scarcity of such resources. In urban areas there may be a multiplicity of resources and programs, which can cause confusion. Access to services varies as eligibility requirements may be different in hospitals, prenatal care clinics, etc., or for income supplementation programs such as WIC, food stamps, etc. Medical care is a serious problem as private insurance coverage for dependents and single persons often does not cover prenatal care and childbirth. Schools are more accepting of pregnant pupils, but there may be barriers which discourage continuation in school. Adoption services continue to be available although not often chosen by adolescents. Child care services are less available because the prevalence of two job families decreases availability of day care homes with relatives or within the community. Cutbacks in state and federal funding have impacted on many programs serving this population group. In an urban area, the challenge of locating needed services and accessing into them is a challenge to professionals.

We recognize that the social climate and peer pressure support plans for most adolescents to rear the child themselves. To plan adoption is considered "chicken" and proves beyond the capacity of many adolescents. To face grief and pain which is self-inflicted, or which is to a large extent determined by parents' refusal to assume parental responsibility for a grandchild, is not accepted behavior for most adolescents, and causes many of them to act against what appears to be their own best interest. The Adolescent Family Life Act recognized these factors and offered grants in support of comprehensive programs services to pregnant girls.

Presenting adoption as a viable alternative is an important component to services to pregnant adolescents as well as part of the educational focus in some demonstration projects geared to adolescents and their parents. The option may not be exercised for a variety of reasons, but at least those involved know of its existence.

Predecessor programs first focused on the client, the pregnant adolescent. As these programs developed, the family and the father of the child were included in services as they were important people in pregnancy and parenting decisions.

The Adolescent Family Life act with its stress on networking and linkages of services and recognition of the conflicts existing within our community regarding the appropriateness (rightness) of some of the solutions and services currently available was a welcome effort to involve as many community groups as possible to have an impact on this serious problem. We supported it initially and continue to do so. We urge reauthorization of the Act and increased funding for the programs.

The money spent under this Act is a small amount relative to the need, but has an impact in the community where the projects exist and in many other communities because of the forward thrust of these programs. The experience gained from these projects will be of great benefit to all of us. As an example of this, we received recently information from a program funded under this Act which makes available to social services agencies TV and radio announcements about services for pregnant adolescents at reasonable costs.

Within the Catholic Charities network, four agencies received grants under the Act in 1982 and 1983. They offer comprehensive care programs providing networking and linkage among existing services, in one instance with a special focus on strengthening the adoption option, or provided a family based prevention program.

Prevention programs have been developed by grant recipients under this Act through demonstration projects. Adolescents and their parents are involved in sessions which stress communication within the family. Facilitators help both the adolescents and their parents discuss their values, the similarities and differences. The adolescents hear the values of other parents and parents have an opportunity to hear those of adolescents other than their own. This family focused approach gives members of the family skills, perhaps not previously developed or refined, to deal with each other openly and honestly. The skills will be an asset in many situations families face, not just in dealing with adolescent sexuality. The consequences of an ill-timed pregnancy may be discussed with some reality testing as to the implications for all as a result. Technical information is given to counter some of the "misinformation" held by the seemingly well informed and sophisticated adolescents. You heard some grant recipients describe their programs at hearings of this Subcommittee on Tuesday.

In preparation for this testimony, I spoke with one of our member agencies which is involved in a hospital based program serving low income, Mexican-American families. The outcome of the project so far has been quite exciting, as all of the mothers had healthy outcomes to pregnancy; they had accessed prenatal care much earlier than experience indicated they would have prior to the initiation of this program. There were language and cultural barriers to their use of existing services which were worked through. Although there were not many adoptions, the staff feel that at least the adolescents were aware of that as a viable alternative. Program staff have found that the use of family therapy sessions with the father and his family and the mother and her family have resulted in many families resolving the stress associated with pregnancy in a much healthier way. Apparently it was a common occurrence for a girl to be excluded from the family and to have to support herself and her child. With the help of family counseling and support services, the families seem to be functioning well in offering needed support to the girl and her child. This particular program has involved a number of community agencies, none of which had worked effectively together before the inception of the program receiving the grant.

Program staff know that the services they offer are effective in their goals and reach the population they are intended for. However, with such a small amount allowed for evaluation as part of the grant award, it is difficult to provide good documentation for program results. Many grant recipients urge that the criteria and resources for evaluation be strengthened under this act. Research and evaluation provide the background for improving services.

Recently the Danforth Foundation sponsored a study of the economic cost of teenage pregnancy to the St. Louis community. The study looked at current and projected economic costs with attention to social factors. While the data included teenagers up to age 19, it was obvious that the costs of medical care were markedly higher in inverse ratio to the age of the mother, that the ability to effect a healthy outcome for the child also was influenced by this factor, and that the cost of providing adequate financial support was higher related to the age of the mother at the time of birth. There was an effort made to quantify this as well as to look at the cost of early child-bearing as reflected by decreased earning capacity and increased reliance on public assistance. There was an estimate that the cost of services such as AFDC and Medicaid, food stamps, housing, and others would average $14,041 annually for each child up to the age of 18. The cost in stressed family life, inability to become self-supporting, and in the total social-emotional impact on the individuals concerned, their families, and the community, of such early childbearing and childrearing cannot be calculated in dollars, nor is it possible to adequately describe it in words.

Many programs concentrate on delaying childbearing when teenagers are sexually active, and others focus on terminating the pregnancy since this has become a legal option. In spite of all of these programs, adolescents continue to have "unplanned pregnancies," thus causing problems for them and their families. We, as representatives of social agencies and as members of a group especially committed to the support of family life and to the value of each child, seek in every way that we can to insure that the economic cost to the community is reduced as much as possible, and that the social, psychological and emotional impact of pregnancies to our adolescent population is minimized to the maximum extent possible. In this quest, we have been heartened by the leadership shown by the Congress in providing funding for the Adolescent Family Life Program. We wish that the dollars available were more adequate when we consider the extent of the need and the high cost of providing services. We believe firmly that when we are given the opportunity to provide services and intervene at the earliest possible moment and with the right mix of services, we can affect more positive outcomes for these children in pregnancy prevention or comprehensive services to the pregnant adolescent and her child.

Senator DENTON. In your area, your geographic area, do you believe that the Adolescent Family Life Programs are well-known in the communities? Do they have sufficient outreach?

Miss SULLIVAN. We were not fortunate enough to get a grant, and there is no Adolescent Family Life Program in our area. The closest is one in Kansas City, which is 250 miles away.

Senator DENTON. In your opinion, in general, throughout the United States, do you think the Adolescent Family Life Programs are sufficiently publicized, and do they have sufficient outreach?

Miss SULLIVAN. I think there is a need for more dissemination of the information that comes through those. I think we are beginning to see some of the effects of that. We got a notice just the other day about a program in Iowa that was telling us about availability of a resource from their work. We hope to hear more of that. But there is certainly much need to make the outcomes of the grants known. And I was thinking that through the network of our Conference of Catholic Charities and our Commission on Unmarried Parents, that we would certainly be in a position to advise people about the availability of the material developed through the grants.

We would be glad to cooperate with the Office on Adolescent Pregnancy in doing that.

Senator DENTON. My next question may be rather comprehensive, and if you would care to develop it further in writing, I would appreciate it. But in your years of work in the Catholic Charities movement, can you recall and relate examples of how church-affiliated organizations such as yours have been able to work to good effect with other private agencies which are not religiously affiliated, as well as with the private sector, in the area of adolescent pregnancy?

Miss SULLIVAN. I certainly can. I know that, for instance, I am a member of the Maternal and Child Health Council in St. Louis, and participate in planning around the area of pregnancy, and that brings together a number of organizations. One of our member agencies, the one in Kansas City, that I am aware of, is in a consortium with a family practice grant in a hospital and a nonsectarian community agency—it includes the YMCA. But they said that this was the first time that any of those had worked well together. So that the act did bring community agencies together. And I think when we work together, we can be more effective.

Senator DENTON. Synergistic. I think that word means something like the sum of your work is exceeded by the effects of that work. And I agree with you, I think when organizations work together, they do more than the sum of their separate work would have amounted to.

Thank you very much for your testimony, Miss Sullivan.

Senator DENTON. Our final witness this morning is Mrs. Margarita Fernandez-Mattei. She is the national coordinator of adolescent pregnancy prevention for the National Coalition of Hispanic Mental Health and Human Services Organizations. They are located here in Washington. The organization endorsed the Adolescent Family Life Program in 1981, and Mrs. Fernandez-Mattei will discuss the need for Adolescent Family Life services in the Hispanic community.

Please begin, Mrs. Fernandez-Mattei.

STATEMENT OF MARGARITA FERNANDEZ-MATTEI, NATIONAL COORDINATOR, ADOLESCENT PREGNANCY PREVENTION, COALITION OF HISPANIC MENTAL HEALTH AND HUMAN SERVICE ORGANIZATIONS, WASHINGTON, DC

Mrs. FERNANDEZ-MATTEI. Good afternoon, Mr. Chairman.

It is a pleasure to be able to present our views before the subcommittee. I am coordinator for the National Coalition of Hispanic Mental Health and Human Service Organizations.

COSSMHO has a National Adolescent Pregnancy Prevention Program grant. COSSMHO works with 220 rural and urban communities in 32 States, the District of Columbia, and Puerto Rico. We work very much in the fields of mental health and human services, and give special emphasis to youth.

In our program, we are using this total national network to disseminate the information on adolescent pregnancy prevention. Major COSSMHO achievements in serving youth and families include: providing career development leadership training to over 6,000 Hispanic teenagers in 14 cities, in cooperation with local agencies, schools, churches, and volunteer groups. We conduct a nationwide series of public forums for youth, public officials, and representatives from service providers, employers, and schools, helping form local networks to follow up on concerns voiced by youth.

COSSMHO also conducts biennial national conferences on human services as well as national Hispanic youth symposium, joining with other local member agencies in cosponsoring statewide and regional conferences on issues affecting Hispanics, including adolescent pregnancy prevention.

COSSMHO utilizes two publications to disseminate this information. Research has proven that early adolescence is a critical developmental period for youth, parents, the family as a whole. Yet more societal attention and resources have been devoted to other key periods, such as early childhood and old age.

Under the rush of fundamental, rapid, and dramatic changes which characterize early adolescence, all families experience disequilibrium. Many experience long and painful disfunction.

As youth cope with profound changes in physical makeup, intellectual capability, and new social frontiers, parents, the family, and other adult role models play a pivotal role in helping them develop confidence and competence by providing them sensitivity, guidance, understanding and support.

Most parents dread the onset of adolescence, the precarious mix of opportunities and dangers it may hold for their particular child, the complex new demands it will make on their time and skills.

A recent survey conducted by National Family Opinion Research, Inc., found that between 64.5 and 82.6 percent of teens agreed with their mothers on such subjects as drugs, education, politics and sex, while between 53 and 75.6 percent agreed with their fathers' views on the same topics.

We must strengthen the family unit, assisting parents to develop skills needed in their efforts to provide children and adolescents with accurate and health information about sexuality, reproduction and respect to self and others. We are striving to teach our youth that responsibility in sexuality, self-respect, and respect for the lives of others is one of the most fundamental and important matters they will face in their young lives.

The youthfulness and fertility of the Hispanic population contrast to the overall aging of America. Hispanics are younger, 22 years median age as compared to 31 years old for other ethnic racial groups, and have larger families. Based on the 1972-80 National Opinion Research Center general social surveys, the birth rates and fertility rates respectively in 1979 were 15.6 and 66.7 for the total sample, while it was 25.5 and 100.5 percent for all Hispanics. Forty-six percent of all Hispanics are under 18 years old. Hispanic adolescents and children are twice as likely to belong to large families—that is, those with seven members or more. Nineteen percent of all Hispanic mothers are under 20 years of age, and this relatively large proportion of births to teenagers is a factor accounting for the lower levels of educational achievement observed among Hispanic women.

In order to help Hispanic adolescents realize their potential as whole human beings, we need to integrate the biological, social, and psychological aspects of their sexuality into all other aspects of their lives. Adolescent sexuality should be dealt with in the context of whole, young human beings in interaction with their personal selves, their peers, their families of the past and the future. It should be taken into account that these are people we are talking about, and not simply owners of reproductive systems.

Adolescent sexuality is also shaped by many sociocultural forces such as: the overall values and norms of the larger society concerning adolescent sexuality, the socioeconomic status of his or her family, race ethnicity, and religion. The particular community in which the individual lives, the cultural patterns of that special place, and the social institutions that serve adolescents play a key role in their development.

In order to reach these Hispanic population groups, cultural heritage and identity must be incorporated in the strategies and service delivery modes. Hispanics are significantly less likely to approve sex education for adolescents than either blacks or whites. Hispanics also perceive the appropriate ages for sex education to be older and are more conservative about the topics and places for sex education than other ethnic groups. In order to reach the Hispanics, these and other important factors should be part of the planning process.

COSSMHO is conducting a national demonstration project in five cities: Albuquerque, Boston, Los Angeles, Miami, and San Antonio. We are giving formal training to the parents to develop parenting skills, and we are utilizing a pyramidal community organization model which will allow us to reach and train 42,000 parents in the five States during a 2-year period. Our design is innovative and brings in existing organizations and agencies to form part of the parental support network. The more support parents and potential parents receive from their community, the more prepared and secure they will be as they take on this difficult responsibility.

Our programs are in their first year of operation, and have produced excitement in our communities, yet it is too early to measure their effects. This model does provide a different alternative to the Hispanic community by helping parents to be the primary sex educators. Our Nation needs to continue exploring these and other new models to find solutions to the crises lived by our families. By supporting concerned parents in a bilingual and bicultural setting on this issue, we may also prevent other negative behavior in our youth.

Although millions of dollars have been invested since 1970 in the traditional provider-oriented approaches, the problem continues to grow substantially. Adolescent pregnancies have increased and so have the number of terminated pregnancies. According to the National Center for Health Statistics, in 1980 there are 1,077,092 pregnancies in adolescents aged 15 to 19 and 28,917 pregnancies in adolescents under 15. Of these, 460,120 were terminated through induced abortions. Successful family planning approaches and services should prevent unwanted pregnancies. Too small a portion of the family planning funds available under titles X and XX of the Public Health Service Act are set aside for preventive efforts or innovative approaches.

I strongly urge you to reauthorize title XX of the Public Health Service Act, the Adolescent Family Life Act of 1981, and to increase the funding available for preventive efforts substantially. Our children and youth are our Nation's future, and worth sparing no efforts to solve this critical problem.

Thank you, Mr. Chairman.

[The prepared statement of Mrs. Fernandez-Mattei follows:]

PREPARED STATEMENT OF MARGARITA FERNANDEZ-MATTEI

MR. CHAIRMAN AND SUBCOMMITTEE MEMBERS:

I AM MARGARITA FERNANDEZ-MATTEI, NATIONAL COORDINATOR OF THE ADOLESCENT PREGNANCY PREVENTION PROGRAM CONDUCTED BY THE NATIONAL ORGANIZATION OF HISPANIC MENTAL HEALTH AND HUMAN SERVICES ORGANIZATIONS (COSSMHO). A PRIVATE NONPROFIT ORGANIZATION, COSSMHO IS A NATIONAL COALITION OF LOCAL HISPANIC-SERVING AGENCIES AND PROFESSIONALS INVOLVED IN SERVICE DELIVERY, TRAINING, AND RESEARCH IN HEALTH, MENTAL HEALTH, HUMAN SERVICES, AND YOUTH SERVICES. COSSMHO AFFILIATES SERVE MEXICAN AMERICAN, PUERTO RICAN, CUBAN-AMERICAN, AND LATINO COMMUNITIES IN OVER 220 URBAN AND RURAL AREAS IN 32 STATES, THE DISTRICT OF COLUMBIA, AND PUERTO RICO. OUR NATIONAL OFFICE IN WASHINGTON, D.C. SERVES AS THE FOCAL POINT FOR INTERCHANGE AND JOINT ACTIVITIES.

MAJOR COSSMHO ACHIEVEMENTS IN SERVING YOUTH AND FAMILIES INCLUDE: PROVIDING CAREER DEVELOPMENT/LEADERSHIP TRAINING TO OVER 6,000 HISPANIC TEENAGERS IN 14 CITIES, IN COOPERATION WITH LOCAL AGENCIES, SCHOOLS, CHURCHES, AND VOLUNTEER GROUPS: CONDUCT OF A NATIONWIDE SERIES OF PUBLIC FORUMS FOR YOUTH, PUBLIC OFFICIALS, AND REPRESENTATIVES FROM SERVICE PROVIDERS, EMPLOYERS, AND SCHOOLS: HELPING FORM LOCAL NETWORKS TO FOLLOW UP ON CONCERNS VOICED BY YOUTH.

COSSMHO ALSO CONDUCTS BIENNIAL NATIONAL CONFERENCES ON HUMAN SERVICES AS WELL AS NATIONAL HISPANIC YOUTH SYMPOSIUM, AND ALSO JOINS WITH LOCAL MEMBER AGENCIES IN CO-SPONSORING STATEWIDE AND REGIONAL CONFERENCES ON ISSUES AFFECTING HISPANICS, INCLUDING ADOLESCENT PREGNANCY PREVENTION. RESEARCH HAS PROVEN THAT EARLY ADOLESCENCE IS A CRITICAL DEVELOPMENTAL PERIOD FOR YOUTH, PARENTS, AND THE FAMILY AS A WHOLE. YET MORE SOCIETAL ATTENTION AND RESOURCES HAVE BEEN DEVOTED TO OTHER KEY PERIODS SUCH AS EARLY CHILDHOOD AND OLD AGE. UNDER THE RUSH OF FUNDAMENTAL, RAPID, AND DRAMATIC CHANGES WHICH CHARACTERIZE EARLY ADOLESCENCE, ALL FAMILIES EXPERIENCE DISEQUILIBRIUM: MANY EXPERIENCE LONG AND

PAINFUL DISFUNCTION. AS YOUTH COPE WITH PROFOUND CHANGES IN PHYSICAL MAKEUP, INTELLECTUAL CAPABILITY, AND NEW SOCIAL FRONTIERS, PARENTS, THE FAMILY, AND OTHER ADULT ROLE MODELS PLAY A PIVOTAL ROLE IN HELPING THEM DEVELOP CONFIDENCE AND COMPETENCE BY PROVIDING THEM SENSITIVITY, GUIDANCE, UNDERSTANDING, AND SUPPORT.

MOST PARENTS DREAD THE ONSET OF ADOLESCENCE, THE PRECARIOUS MIX OF OPPORTUNITIES AND DANGERS IT MAY HOLD FOR THEIR PARTICULAR CHILD, THE COMPLEX NEW DEMANDS IT WILL MAKE ON THEIR TIME AND SKILLS.

A RECENT SURVEY CONDUCTED BY NATIONAL FAMILY OPINION RESEARCH, INC. FOUND THAT BETWEEN 64.5 PERCENT AND 82.6 PERCENT OF TEENS AGREED WITH THEIR MOTHERS ON SUCH SUBJECTS AS DRUGS, EDUCATION, POLITICS, AND SEX, WHILE BETWEEN 53 AND 75.6 PERCENT AGREED WITH THEIR FATHERS' VIEWS ON THE SAME TOPICS.

WE MUST STRENGTHEN THE FAMILY UNIT, ASSISTING PARENTS TO DEVELOP SKILLS NEEDED IN THEIR EFFORTS TO PROVIDE CHILDREN AND ADOLESCENTS WITH ACCURATE AND HEALTHY INFORMATION ABOUT SEXUALITY, REPRODUCTION AND RESPECT TO SELF AND OTHERS. WE ARE STRIVING TO TEACH OUR YOUTH THAT RESPONSIBILITY IN SEXUALITY, SELF RESPECT, AND RESPECT FOR THE LIVES OF OTHERS IS ONE OF THE MOST FUNDAMENTAL AND IMPORTANT MATTERS THEY WILL FACE IN THEIR YOUNG LIVES.

THE YOUTHFULNESS AND FERTILITY OF THE HISPANIC POPULATION CONTRAST TO THE OVERALL AGING OF AMERICA. HISPANICS ARE YOUNGER (THE MEDIAN AGE IS 22 VS. 31 FOR OTHER ETHNIC RACIAL GROUPS) AND HAVE LARGER FAMILIES. BASED ON THE 1972-80 NATIONAL OPINION RESEARCH CENTER GENERAL SOCIAL SURVEYS, THE BIRTH RATES AND FERTILITY RATES RESPECTIVELY IN 1979 WERE 15.6 AND 66.7 FOR THE TOTAL SAMPLE WITH 25.5 AND 100.5 FOR ALL HISPANICS (29.7 AND 119.3) FOR THOSE

OF MEXICAN ORIGIN: 22.6 AND 80.7 FOR PUERTO RICANS: 8.6 AND 39.7 FOR CUBANS: 25.7 AND 95.9 FOR OTHER HISPANICS). FORTY SIX PERCENT (46%) OF ALL HISPANICS ARE UNDER 18 YEARS OLD. HISPANIC ADOLESCENTS AND CHILDREN ARE TWICE AS LIKELY TO BELONG TO LARGE FAMILIES (THAT IS, THOSE INCLUDING SEVEN OR MORE MEMBERS) THAN THE GENERAL POPULATION. NINETEEN PERCENT OF HISPANIC MOTHERS ARE UNDER TWENTY YEARS OF AGE AND THIS RELATIVELY LARGE PROPORTION OF BIRTHS TO TEENAGERS IS A FACTOR ACCOUNTING FOR THE LOWER LEVELS OF EDUCATIONAL ACHIEVEMENT OBSERVED AMONG HISPANIC WOMEN.

IN ORDER TO HELP HISPANIC ADOLESCENTS REALIZE THEIR POTENTIAL AS WHOLE HUMAN BEINGS, WE NEED TO INTEGRATE THE BIOLOGICAL, SOCIAL AND PSYCHOLOGICAL ASPECTS OF THEIR SEXUALITY INTO ALL OTHER ASPECTS OF THEIR LIVES. ADOLESCENT SEXUALITY SHOULD BE DEALT WITH IN THE CONTEXT OF WHOLE, YOUNG HUMAN BEINGS IN INTERACTION WITH THEIR PERSONAL SELVES, THEIR PEERS, THEIR FAMILIES OF THE PAST AND THE FUTURE. IT SHOULD TAKEN INTO ACCOUNT THAT THESE ARE "PEOPLE" WE ARE TALKING ABOUT NOT SIMPLY OWNERS OF REPRODUCTIVE SYSTEMS.

ADOLESCENT SEXUALITY IS ALSO SHAPED BY MANY SOCIO-CULTURAL FORCES SUCH AS: THE OVERALL VALUES AND NORMS OF THE LARGER SOCIETY CONCERNING ADOLESCENT SEXUALITY, THE SOCIOECONOMIC STATUS OF HIS/HER FAMILY, RACE ETHNICITY, AND RELIGION. THE PARTICULAR COMMUNITY IN WHICH THE INDIVIDUAL LIVES, THE CULTURAL PATTERNS OF THAT SPECIAL PLACE, AND THE SOCIAL INSTITUTIONS THAT SERVES ADOLESCENTS PLAY A KEY ROLE IN THEIR DEVELOPMENT.

IN ORDER TO REACH THESE HISPANIC POPULATION GROUPS CULTURAL HERITAGE AND IDENTITY MUST BE INCORPORATED IN THE STRATEGIES AND SERVICE DELIVERY MODES. IN ACCORDANCE WITH A SURVEY CONDUCTED BY COLUMBIA UNIVERSITY, HISPANICS ARE SIGNIFICANTLY LESS LIKELY TO APPROVE SEX EDUCATION FOR ADOLESCENTS THAN EITHER BLACK OR WHITES. HISPANICS ALSO PERCEIVE THE APPROPRIATE AGES FOR SEX EDUCATION TO BE OLDER, AND ARE MORE CONSERVATIVE ABOUT THE TOPICS AND PLACES FOR SEX

EDUCATION THAN ARE OTHER ETHNIC GROUPS. IN ORDER TO REACH THE HISPANICS THESE AND OTHER IMPORTANT FACTORS SHOULD BE PART OF THE PLANNING PROCESS.

COSSMHO IS CONDUCTING A NATIONAL DEMONSTRATION PROJECT IN FIVE CITIES, WHICH FOCUSES ON DEALING WITH CONCERNED PARENTS WHO WANT TO CARRY OUT THEIR RESPONSIBILITIES AS THE PRIMARY SEX EDUCATORS OF THEIR CHILDREN AND YOUTH. THE PROJECT'S GOAL IS TO HELP PREVENT AND REDUCE THE INCIDENCE OF ADOLESCENT PREMARITAL SEXUAL ACTIVITY, INCLUDING ADOLESCENT PREGNANCY, BY ORGANIZING AND MOBILIZING GROUPS OF VOLUNTEER PARENTS AND OTHER FAMILY MEMBERS AROUND THIS CRITICAL ISSUE AT THE LOCAL LEVEL BY FOSTERING LOCAL NETWORKS SUPPORTIVE OF THESE GROUPS. THE DEMONSTRATION PROJECT IS DIRECTED TOWARD HISPANIC COMMUNITIES IN ALBUQUERQUE, BOSTON, LOS ANGELES, MIAMI AND SAN ANTONIO. WE ARE UTILIZING A PYRAMIDAL COMMUNITY ORGANIZATION MODEL WHICH WILL TRAIN AN ESTIMATED FORTY-ONE THOUSAND PARENTS IN THE FIVE STATES DURING A TWO YEAR PERIOD. THE DESIGN PROVIDES FOR THE ESTABLISHMENT OF A PERMANENT MOVEMENT BY THE CONCERNED PARENTS, WHO WILL CONTINUE TO INVOLVE OTHER PARENTS. OUR DESIGN IS INNOVATIVE AND BRINGS IN EXISTING ORGANIZATIONS AND AGENCIES TO FORM PART OF THE PARENTAL SUPPORT NETWORK. THE MORE SUPPORT PARENTS AND POTENTIAL PARENTS RECEIVE FROM THEIR COMMUNITY, THE MORE PREPARED AND SECURE THEY WILL BE AS THEY TAKE ON THIS DIFFICULT RESPONSIBILITY.

OUR PROGRAMS ARE IN THEIR FIRST YEAR OF OPERATION AND HAVE PRODUCED ENTHUSIASM IN OUR COMMUNITIES, YET IT IS TOO EARLY TO MEASURE THEIR EFFECT.

THIS MODEL PROVIDES A DIFFERENT ALTERNATIVE TO THE HISPANIC COMMUNITIES BY HELPING PARENTS TO BE THE PRIMARY SEX EDUCATORS. OUR NATION NEEDS TO CONTINUE EXPLORING THESE AND OTHER NEW MODELS TO FIND SOLUTIONS TO THE CRISES LIVED BY OUR FAMILIES. BY SUPPORTING CONCERNED PARENTS IN A BILINGUAL AND BICULTURAL SETTING ON THIS ISSUE, WE MAY ALSO PREVENT OTHER NEGATIVE BEHAVIOR IN OUR YOUTH.

ALTHOUGH MILLIONS OF DOLLARS HAVE BEEN INVESTED SINCE 1970 IN THE TRADITIONAL PROVIDER-ORIENTED APPROACHES, THE PROBLEM CONTINUES TO GROW SUBSTANTIALLY. ADOLESCENTS PREGNANCIES HAVE INCREASED AND SO HAVE THE NUMBER OF TERMINATED PREGNANCIES. ACCORDING TO THE NATIONAL CENTER FOR HEALTH STATISTICS, IN 1980 THERE WERE 1,077,092 PREGNANCIES IN ADOLESCENTS AGED 15 TO 19 AND 28,917 PREGNANCIES IN ADOLESCENTS AGED UNDER 15. OF THESE, 460,120 WERE TERMINATED THROUGH INDUCED ABORTIONS. SUCCESSFUL FAMILY PLANNING APPROACHES AND SERVICES SHOULD PREVENT UNWANTED PREGNANCIES. YET, TOO SMALL A PORTION OF THE FAMILY PLANNING FUNDS AVAILABLE UNDER TITLES X AND XX OF THE PUBLIC HEALTH SERVICE ACT ARE SET ASIDE FOR PREVENTIVE EFFORTS OR INNOVATIVE APPROACHES.

I STRONGLY URGE YOU TO REAUTHORIZE TITLE XX OF THE PUBLIC HEALTH SERVICE ACT AND TO INCREASE THE FUNDING AVAILABLE FOR PREVENTIVE EFFORTS SUBSTANTIALLY. OUR CHILDREN AND YOUTH ARE OUR NATION'S FUTURE AND WORTH SPARING NO EFFORTS TO SOLVE THIS CRITICAL PROBLEM.

THANK YOU

Senator DENTON. Thank you. I will ask you only two questions. You ran over your time, but I could see that the information you were going to give me was information I would have solicited in questions.

Are Hispanics more likely to accept a sex education program that is thought to be more traditional and if so, why?

Mrs. FERNANDEZ-MATTEI. Our culture is very conservative. The Hispanic communities within the United States differ among themselves, but we do have in common that we are more conservative, and that traditionally, the family looks within itself to educate its children in sensitive and value matters.

Therefore, they are more inclined to use services that agree with their personal values.

On the other hand, our youth are torn between a family-centered tradition and a peer-centered tradition. That is why we need to fortify the parenting skills and help the parents carry out this difficult mission.

Senator DENTON. With that strong consideration, what would you see as the best approach for targeting large Hispanic communities with a program like the Adolescent Family Life Act? Who should be the actors in the program?

Mrs. FERNANDEZ-MATTEI. In the planning and in the delivery of services, I would strongly urge that Hispanics be involved in the development and planning of both. It does not have to be in an exclusive way, but the cultural values and the cultural differences must be taken into consideration before we can actually be effective in reaching these communities.

Senator DENTON. What kind of community organizations would you believe necessary to be involved to insure that such a program would be acceptable to an Hispanic community?

Mrs. FERNANDEZ-MATTEI. I would say both sectarian and nonsectarian. The Hispanic community's traditional support network includes sectarian sources and nonsectarian sources. The thing that we should stress is that it be community organizations that are sensitive to the cultural difference and the value differences and the more conservative and traditional approach of the Hispanic community.

The networks that we are using include the whole range of agencies, and we are making a special effort to assist the existing organizations to be more aware of these cultural differences so that they can be more effective in serving the Hispanic communities. In the case of sexuality education, a lot of euphemisms have to be used, rather than addressing the issue by the more clear terms, because our communities are quite, quite conservative.

Senator DENTON. Granting the statistical, relatively high conservatism among Hispanics, but also highlighting the remark you made that among Hispanics, there are differences, and we know that among whites of different persuasions and blacks of different persuasions, there are differences, too. It would appear to me that those families and the organizations which serve those different types of people should be sensitive to their respective beliefs about the kind of sex counseling that should be offered to them, and the communities which should be involved in the overall approach to that subject. I feel sure you would agree with that.

Mrs. **Fernandez-Mattei**. Yes, Mr. Chairman, I agree totally.

Senator **Denton**. Well, I want to thank you very much, Mrs. Fernandez-Mattei. It was very valuable testimony.

I would like to thank the audience and all the witnesses for their contributions, attention, and patience during the two reauthorization hearings. These are the only two that we plan. And I say again that I shall be introducing a bill soon to reauthorize the Adolescent Family Life Demonstration Projects Act for 3 years at the current authorization level of $30 million. If any of you are interested in contributing support or criticism to that, I hope there will be more of the former than the latter.

Thank you again. This hearing stands adjourned.

[Whereupon, at 12:17 p.m., the subcommittee was adjourned.]

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